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ABSTRACT

This report provides information on: (1) demographic changes in the elderly population; (2) the relationship of these changes to the retirement income status of the elderly and expenditures for acute health care and long-term care services; and (3) the extent to which potential changes to federal programs could affect the needs of the elderly. The report demonstrates that certain groups of elderly remain below or just above the poverty line. The health care needs of the elderly, how those needs affect their economic status, and current and proposed efforts to deal with increasing health care costs are discussed. The report includes an executive summary and five chapters. Chapter 1 gives the background, objectives, scope, and methodology of the report. Chapter 2 notes that the retirement income status of the elderly has improved, but that several groups are still poor, including women, minorities, and persons aged 85 and over. Chapter 3 examines the high cost of acute medical care as a major problem for some elderly. Chapter 4 considers long-term care as a growing problem, especially for the elderly and their families. Chapter 5 provides concluding observations. Seven tables and five figures are included. (NB)

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GAO

United States General Accounting Office

Report to the Chairman, Subcommittee on Intergovernmental Relations and Human Resources, Committee on Government Operations, House of Representatives

AN AGING SOCIETY

Meeting the Needs of the Elderly While Responding to Rising Federal Costs

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-223880

September 30, 1986

The Honorable Ted Weiss
Chairman, Subcommittee on Intergovernmental
Relations and Human Resources
Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

With this report, we respond to your request for information on demographic changes in the elderly population; the relationship of these changes to the retirement income status of the elderly and expenditures for acute health care and long-term care services; and the extent to which potential changes to federal programs could affect the needs of the elderly.

In addition to documenting the income status of the elderly population, we demonstrate that certain groups of elderly remain below or just above the poverty line. In the report, we also discuss the health care needs of the elderly and how those needs affect their economic status and current and proposed efforts to deal with increasing health care costs.

We plan no further distribution of this report until 30 days from its issue date unless you publicly announce its contents earlier. At that time, copies will be sent to various congressional committees and subcommittees concerned with aging, retirement income, and health as well as the Department of Health and Human Services and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

America's elderly population—persons 65 and older—is projected to increase from 28.6 million in 1985 to 39.2 million by 2010 and 64.6 million by 2030. During this time, public spending on the elderly—an estimated $263 billion in 1985 or nearly half of all federal domestic spending— also is expected to rise significantly.

In response to a request from the Chairman of the Subcommittee on Intergovernmental Relations and Human Resources, House Committee on Government Operations, GAO provides in this report information on these projections. Among issues addressed are (1) demographic changes projected for the elderly population, (2) the relationship of these changes to the economic and health care status of the elderly, and (3) how changes in federal health and retirement programs could affect current and future needs of the elderly.

Background

The number of U.S. elderly, which has been growing steadily in this century, represents an estimated 12.4 percent of the population. Between now and 2010, the number of elderly is expected to increase by 10.6 million to 13 percent; most of this growth (5.9 million) will occur in the 80 and older age group.

The incomes of the elderly also have risen substantially in recent years, and they now receive a larger percentage of the federal budget. While less than 15 percent in 1960, this percentage nearly doubled by 1985 to 28 percent. Continued increase is projected, mostly in health programs because of the greater increase in numbers of elderly in their eighties and older and the expected rise in general health care costs.

Concurrent with these trends are continuing fiscal and political pressures to reduce federal spending. Some of this stems from efforts to cut the budget and reduce the large federal deficit, estimated at $224 billion for fiscal year 1986. Additional pressure is due to problems in Medicare's Hospital Insurance Trust Fund, projected to be out of money in the late 1990's. Medicare is the federal health insurance program for the elderly and disabled.

This combination of demographic and budgetary factors could bring programs for the elderly under increasing review.

Results in Brief

Several key issues and concerns regarding the economic and health status of the elderly will need consideration if programs for them are examined.

First, while the income status of the elderly has improved significantly over the last two decades, much of this is due to growth in Social Security and public and private retirement benefits. Any reduction in this support could jeopardize their improved economic status. In addition, many elderly continue to have low incomes or incomes at just above the poverty line.

Second, the rising costs of health care pose a major threat to the retirement income status of the elderly. Greater out-of-pocket costs can deter them from obtaining care, especially elderly with low incomes. Finally, for some elderly, the cost of long-term care causes a financial catastrophe. Expenditures for these services also are projected to expand, due to not only the rise in the elderly population, but the increased percentage of those eighty and older, the highest users of these services.

Principal Findings

Role of Social Security Significant

Much of the improvement in the economic status of the elderly has been due to the growth in public and private retirement benefits. Social Security is the program providing the most support to the elderly, particularly at the lowest income levels. In 1984, Social Security represented 82 percent of income for couples with the lowest income and 18 percent for those with the highest. Among individuals, Social Security's share was 75 percent of income for those in the lowest income group and 22 percent for the highest.

Income of Many Elderly Still Low

Despite overall improvement in economic status, 12.4 percent or 3.3 million elderly had incomes below the poverty level in 1984. The figure for the rest of the population was 14.7 percent.

More elderly, however, remained close to the poverty level than did members of other age groups. In 1984, almost 30 percent of elderly were in households with incomes below 1.5 times the poverty threshold (compared with 24 percent for persons under 65). Also, 43 percent of elderly

had incomes less than twice the poverty level (compared with 35 percent for the nonelderly).

Certain Groups More Likely to Be Poor

Poverty among the elderly was disproportionate in certain subgroups making up a large number of the poor elderly population, i.e.:

- For women, the poverty rate was nearly twice the rate for men,
- Among black elderly, the poverty rate was nearly three times the rate for white elderly, and
- Persons 85 and older were twice as likely to be living below the poverty line as were persons 65 through 74.

As Population Ages, Health Expenditures Will Increase

As the elderly population becomes larger and older, health care costs (which for Medicare were estimated at $71.4 billion in fiscal year 1985) also are projected to increase. This is because the elderly on average use more health services and spend more on care than do people under age 65. These rising costs cause problems for many elderly.

Elderly May Be Deterred From Seeking Care

For the estimated 20 percent of the elderly who rely on Medicare and lack other private or public coverage, high out-of-pocket costs can deter them from obtaining health care. Also, recent Medicare cost containment measures, including a new form of hospital reimbursement (prospective payment), have increased concerns over quality and access to care for elderly beneficiaries.

In response to the continuing rise in Medicare costs, one option the administration has proposed is to increase cost sharing for beneficiaries. This, however, disproportionately affects the poor and near-poor elderly who have only Medicare coverage. But more cost containment initiatives are likely to be proposed due to Medicare's problems in financing hospital care and the rapidly increasing costs for medical care.

Long-Term Care Costs Catastrophic for Some Elderly

The unanticipated, often catastrophic cost of long-term care is the major threat to the financial well-being of the elderly. Historically, family and friends often have provided assistance to elderly individuals in need of this care, usually without public assistance. Generally, only when the individual becomes impoverished do public programs help. This is particularly true of Medicaid, a federal/state program of medical assistance for the poor.

Many states have tried to slow the growth of their Medicaid programs and contain costs by restricting the nursing home bed supply and controlling reimbursement. Because of high nursing home occupancy, such efforts often make access more difficult for Medicaid recipients. In addition, under Medicare's new Prospective Payment System, patients are discharged earlier from acute care hospitals than in the past and with a greater need for nursing home or home health care, thus increasing demand and expenditures for these services.

Increased Costs for Long-Term Care Foreseen

Current problems in paying for long-term care could become more pronounced in the next few decades. Not only is the population eighty and older, those most likely to need such care, increasing faster than all elderly, but family members and friends may be less able to provide home care in the future. Reasons for this include (1) an increased ratio of elderly parents to children to look after them as a result of increased life expectancy, delayed marriage, and fewer children per family on average, and (2) increased participation of women in the labor force, which may reduce the time available to spend providing home care. With a decline in informal care, more elderly would have to pay for these services, and out-of-pocket costs for long-term care would likely increase further.

Recommendations

GAO makes no specific recommendations. But GAO believes that over the next several years the Congress will have to address these key issues: (1) Medicare financing problems, (2) the impact on the poor elderly of greater out-of-pocket health care costs, and (3) how to finance the increasing costs of long-term care for the growing elderly population.

Agency Comments

GAO did not request official agency comments on a draft of this report.

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Abbreviations

ADL	Activities of Daily Living
CBO	Congressional Budget Office
DOL	Department of Labor
DRG	diagnosis related group
GAO	General Accounting Office
GNP	gross national product
GPO	U.S. Government Printing Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HI	Hospital Insurance
IADL	Instrumental Activities of Daily Living
ICF	intermediate care facility
IRA	Individual Retirement Account
PPS	Prospective Payment System
SMI	Supplementary Medical Insurance
SNF	skilled nursing facility
SSI	Supplemental Security Income

Introduction

The population of Americans age 65 and older, comprising 28.6 million individuals, is projected to increase to 39.2 million by 2010 and to 64.6 million by 2030. During this period, public expenditures for the elderly, now nearly half of all federal domestic spending, also are projected to increase significantly as a share of total expenditures.

Over the next several years, health care and other programs for the population 65 and older could come under increasing review. Among the reasons for this are projected growth in the share of public resources allocated to the elderly, financing problems in Medicare's Hospital Insurance program (which, it is predicted, will run out of money in the late 1990's), and pressure to reduce the large federal deficit.

Background

Almost One in Eight Americans Is 65 or Older

Since the turn of the century, the number of elderly (individuals age 65 and older) has been growing steadily relative to the population under age 65. In 1900, there were 3.1 million elderly, representing 4 percent of the population. By 1960, their numbers had increased more than five-fold to 16.6 million, 9.2 percent of the population,[1] and by 1985 to an estimated 28.6 million people. Currently, the elderly represent nearly one in every eight Americans, or 12.4 percent of the estimated 238.2 million people in the United States.[2]

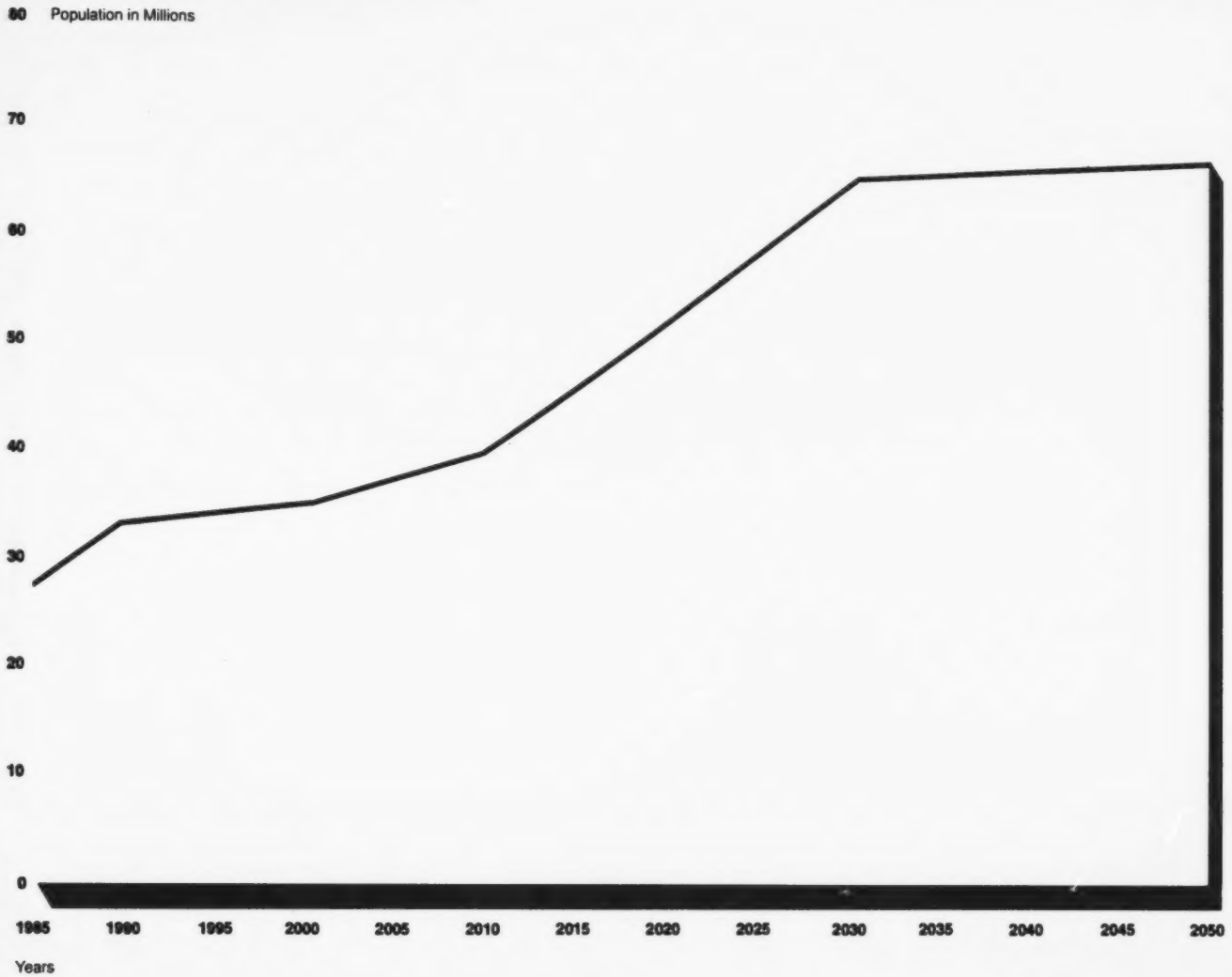
Based on the Census Bureau's middle-series projections regarding life expectancy, fertility rates, and immigration, the number of elderly is expected to increase by more than one-third to 39.2 million by the year 2010. They are then projected to grow by over 60 percent to 64.6 million in 2030 and to 67.4 million in 2050 (see fig. 1.1). The major increase in the numbers of elderly between 2010 and 2030 reflects the large numbers of individuals born between 1946 and 1964 (the "baby boom" generation) turning 65. In 2010, the elderly will represent about 13 percent

[1]Taeuber, Cynthia M., America in Transition: An Aging Society, U.S. Bureau of the Census, Current Population Reports, Special Studies, Series P-23, No. 128 (Washington, D.C.: GPO, 1983), p. 3.

[2]Bureau of the Census, Projections of the Population of the United States, by Age, Sex, and Race: 1983 to 2080. Publication P-25, No. 952 (Washington, D.C.: GPO, 1984), pp. 43-44.

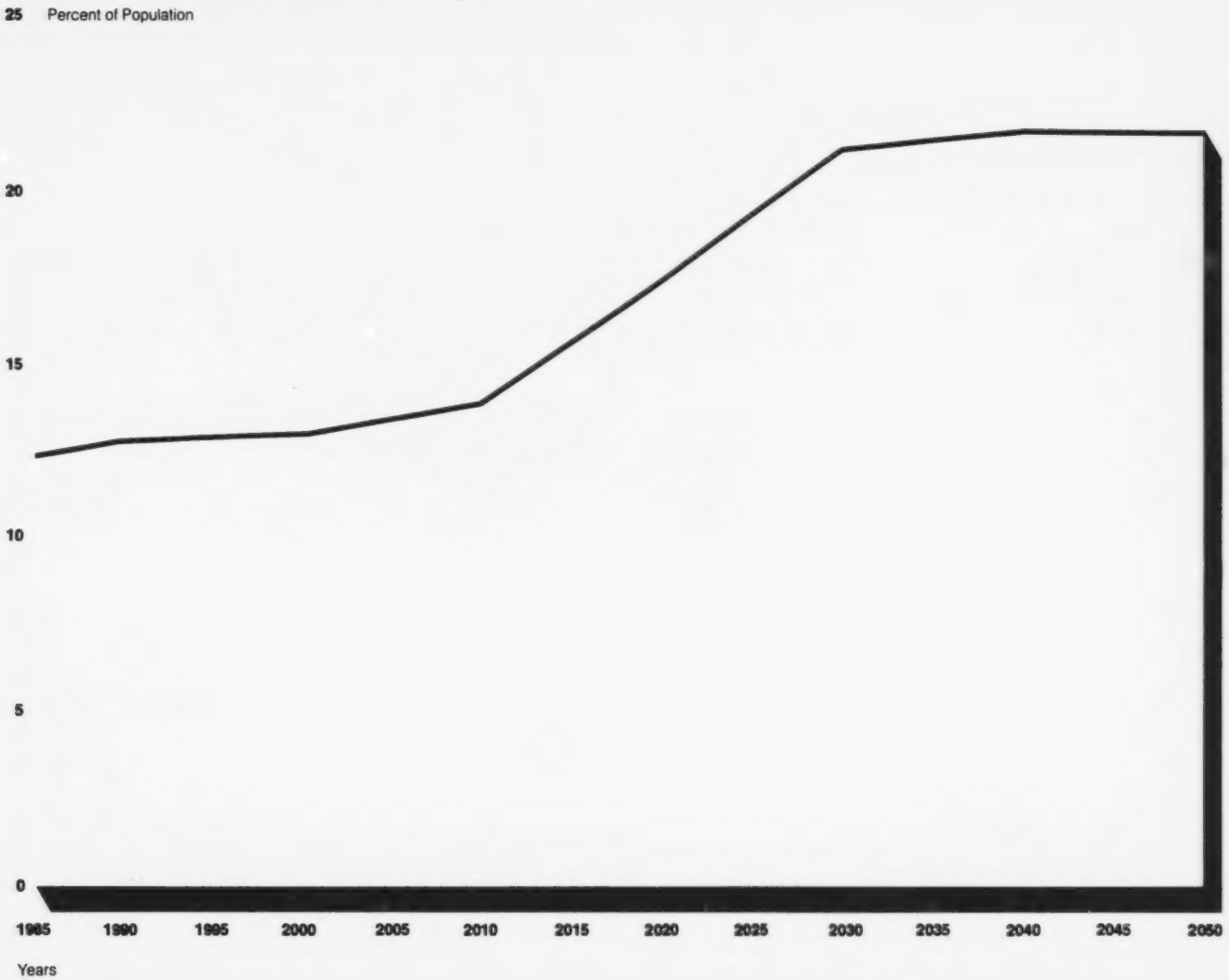
of the total population, in 2030 about 21 percent, and in 2050 about 22 percent (see fig. 1.2).[3]

Figure 1.1: Projected Elderly Population (1985-2050)



[3]Taeuber, Cynthia M., "Age Structure of the U.S. Population in the 21st Century," a Pre-Conference Working Paper presented at the First Annual Conference of Americans for Generational Equity (Washington, D.C., Apr. 10, 1986), p. 4.

Figure 1.2: Projected Elderly as Percent of Total Population (1985-2050)



Increasing Fastest: Oldest Elderly, Blacks, Elderly Living Alone

In 1985, about a third of the elderly population were between the ages of 65 and 69, as shown in table 1.1. Another 27 percent were between 70 and 74, and nearly one in ten (9.4 percent) were 85 and older. Between now and 2010, the elderly population is expected to grow by 10.6 mil-

lion people; most of this growth (5.9 million) will occur in the 80 and older groups (see table 1.2).[4]

Table 1.1: Projected Distribution of the Elderly Population by Age (1985-2050)

Numbers show percent distribution

	Year			
Age group	**1985**	**2010**	**2035**	**2050**
66 to 69	32.2	29.9	24.0	24.6
70 to 74	26.6	21.8	24.3	20.0
75 to 79	19.6	17.4	21.0	17.1
80 to 84	12.2	14.0	14.8	14.5
85 and over	9.4	16.9	16.0	23.7
Total	**100.0**	**100.0**	**100.0[a]**	**100.0[a]**

[a]Total does not add to 100 due to rounding.

Source: Computed from Bureau of the Census Publication Series P-25, No. 952, 1984.

Table 1.2: Projected Increases in the Elderly Population by Age (1985-2050)

In millions of people

	Year		
Age group	**1985-2010**	**2010-2035**	**2035-2050**
65 to 69	2.5	4.3	0.6
70 to 74	1.0	7.6	−2.7
75 to 79	1.2	7.2	−2.5
80 to 84	2.0	4.4	−0.1
85 and over	3.9	4.1	5.3
Total elderly	**10.6**	**27.6**	**0.6**

Source: Computed from Bureau of the Census Publication Series P-25, No. 952, 1984.

Currently, compared to the white population, a smaller proportion of the black population is 65 and older. In 1980, 7.8 percent of the black population was 65 and older versus 11.9 percent of the white population. The difference is primarily the result of higher birth rates and secondarily due to the higher mortality rates among blacks.[5] Recently, however, the number of elderly blacks has been increasing faster than the number of elderly whites, and this trend is expected to continue. Between 1970 and 1980, the proportion of the black population who were 65 and older increased by 35 percent compared to a 27-percent increase in the white population.[6]

[4]Bureau of the Census, P-25, No. 952, pp. 43, 77.

[5]Bureau of the Census, Demographic and Socioeconomic Aspects of Aging in the United States, Series P-23, No. 138 (Washington, D.C.: Aug. 1984), pp. 21-22.

[6]Bureau of the Census, P-23, No. 138, pp. 26-27.

In the past few decades, there also has been an increase in the number and percentage of elderly, particularly women, who either live alone or with someone who is not a relative. In fact, the current generation of elderly is the first in which the majority of surviving spouses, mostly women, live alone. [7] In 1960, 50 percent of widows between the ages of 65 and 74 lived in families; by 1980 this had dropped to 27 percent. The rate among the older widowed group, those 75 and older, declined similarly from 60 percent in 1960 to 27 percent in 1980.[8] Thus by 1985, 71 percent of elderly widowed women and 68 percent of elderly widowed men either lived alone or with a nonrelative.[9]

Life Expectancy Increasing

Since the turn of the century, there have been impressive gains in life expectancy. In 1960, a 65-year-old female could expect to live to be 80.8 years old; a male to be 77.8 years old. Twenty-four years later, life expectancy had risen to the point where a 65-year-old female could expect to live to be 83.7 years old and a male to be 79.5 years.[10] As a result, increasing numbers of people are living into their eighties, nineties, and even hundreds.

In the future, life expectancy for a 65-year-old female is expected to increase (as shown in fig. 1.3) to

- 86.1 years in 2010,
- 87.3 years in 2035, and
- 88 years in 2050.

For males, life expectancy at age 65 is expected to be

- 81.1 years in 2010,
- 82 years in 2035, and
- 82.6 in 2050.[11]

[7]Crystal, Stephen, America's Old Age Crisis (New York: Basic Books Inc., 1982), p. 27.

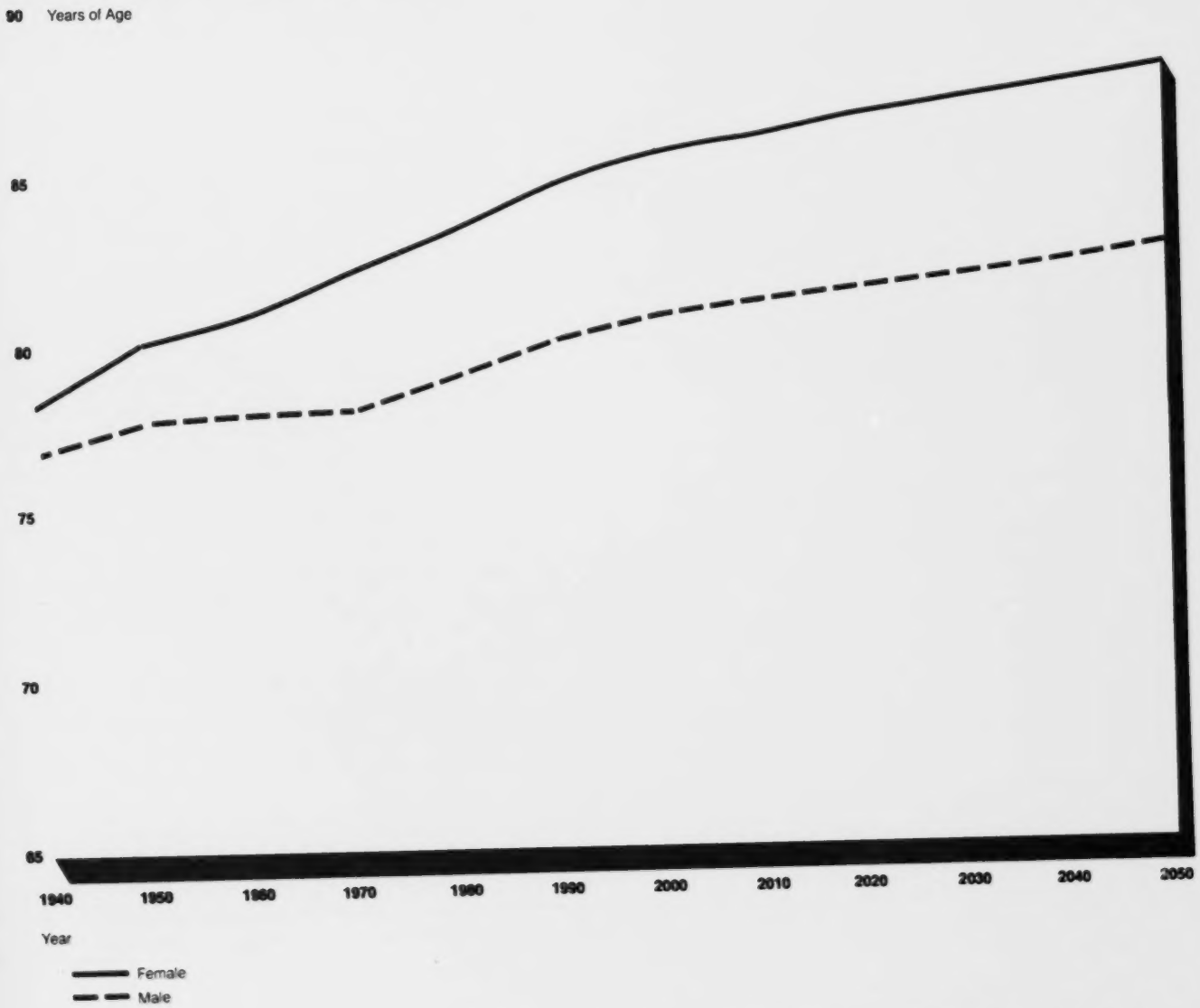
[8]Crystal, p. 42.

[9]House Committee on Ways and Means, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means (1986 ed.), (Washington D.C.: GPO, 1986), p. 76.

[10]Department of Health and Human Services (HHS), National Center for Health Statistics, Health, United States, 1985. (Hyattsville, Md., December 1985, p. 40. (Also see Taeuber, p. 16.)

[11]HHS, Social Security Administration, Social Security Area Population Projections 1985, Pub. No. 11-11542 (Oct. 1985), p. 33.

Figure 1.3: Life Expectancy at Age 65 by Sex (1940-2050)



If there are further increases in life expectancy due to major breakthroughs in treating such diseases as cancer or heart disease, projections in the growth of the elderly population may be understated.

Expenditures for Elderly Increasing

While the elderly are increasing as a proportion of the total population, they also are receiving a larger percentage of the federal budget. In 1960, less than 15 percent of the federal budget went to programs for the elderly. In fiscal year 1985, that proportion had nearly doubled, to 28 percent.[12] As a percentage of the gross national product (GNP), expenditures on the elderly also have been rising. In 1970, pension and health care financing programs consumed 6.1 percent of GNP; by 1986, 9.6 percent, an increase of over one-half.[13]

Partially accounting for this increase in federal expenditures for the elderly has been the growing number of elderly receiving Social Security. Also contributing have been legislated improvements to income protection, health insurance, and services enacted in the 1960's and 1970's to reduce the high levels of poverty among the elderly.[14]

In 1985, federal expenditures for the elderly represented nearly half of all domestic program spending or an estimated $263 billion. Social Security represented 55 percent of these expenditures and Medicare 23 percent. Other (nonveteran) retirement programs accounted for 10 percent, and the remainder consisted of Medicaid (4 percent), housing (2 percent), veterans' retirement (2 percent), Supplemental Security Income (SSI—1 percent), and other programs (4 percent).[15] Assuming current program commitments, federal expenditures for the elderly are projected to continue to grow as the elderly population increases in the future.

Health programs will account for most of this future growth in federal expenditures for the elderly because of (1) the anticipated rise in general health care costs, which are expected to grow at a higher rate than the GNP, and (2) the projected higher rate of increase in the number of very old, who are more likely to need health services. One projection shows federal health care financing programs growing from their 2.7-percent share of GNP in 1985, to 4.5 percent in 2010, 5.2 percent in 2020, and 6.1 percent in 2035 with most of the growth attributable to health

[12]U.S. Senate, Special Committee on Aging, Aging America: Trends and Projections (1985-6 ed.), (Washington, D.C.: GPO, 1986), p. 122.

[13]Palmer, John L., and Barbara Boyle Torrey, "Health Care Financing and Pension Programs" in Gregory B. Mills and John L. Palmer, eds., Federal Budget Policies in the 1980s (The Urban Institute Press: Washington, D.C., 1984), p. 125.

[14]U.S. Senate, Special Committee on Aging, p. 122.

[15]U.S. Senate, Special Committee on Aging. Also see Lynn Etheredge, "An Aging Society and the Federal Deficit," Milbank Memorial Fund Quarterly/Health and Society, Vol. 26, No. 4, 1984, p. 521.

programs for the elderly.[16] Among the population 80 and older, higher spending per person combined with the fact that this age group will be increasing at a faster rate than the younger elderly over the next several decades, is one major reason for the overall increase in public expenditures. In 1984, elderly persons 80 years old and older received an average of $8,321 in federal benefits; this was more than 17 percent higher than the $7,151 received by the average 65-to-69-year-old.[17]

Projections for the year 2000 show benefits paid to the 65-to-69 age group remaining the same as the 1984 level of $65 billion in constant 1984 dollars, due to the slight decline in this group's numbers. Benefits for the 80 and older group, however, are projected to rise by $33 billion, from $49.8 billion to $82.8 billion in constant 1984 dollars.[18]

Changes in Budget Policy for Elderly Possible

Given the projected growth in the share of public resources allocated to the elderly, there are increasing fiscal and political pressures to examine current government policies and programs providing assistance to the elderly. Some of this pressure stems from efforts to cut the budget and reduce large deficits.[19]

While estimates of the actual size of the deficit are continually being revised, in February 1986 the Congressional Budget Office (CBO) estimated that the deficit for fiscal year 1986 would be over $200 billion.[20] In August 1986, CBO raised this estimate to $224 billion, a new record.[21] (The deficit for fiscal year 1985 was $212 billion.) Current attention to the effect of federal deficits on the economy has placed increasing pressure on cutting federal expenditures in all areas of the government. While program expenditures for the elderly have not been cut as much

[16]Palmer, John L., and Stephanie Gould, "The Economic Consequences of an Aging Society," Daedalus, Vol. 115, No. 1, Winter 1986, p. 312.

[17]Torrey, Barbara Boyle, "Sharing Increasing Costs on Declining Income: The Visible Dilemma of the Invisible Aged," Milbank Memorial Fund Quarterly/Health and Society, Vol. 63, No. 2, 1985, pp. 379, 383.

[18]Torrey.

[19]See Eric A. Kingson, Barbara A. Hirshorn, and Linda A. Harootyan, The Common Stake: The Interdependence of Generations (Washington, D.C.: The Gerontological Society), 1986, and Dorothy P. Rice, "Living Longer in the United States: Health, Social and Economic Implications," The Journal of Medical Practice Management, Vol. 1, No. 3, pp. 162-169.

[20]CBO, The Economic and Budget Outlook: Fiscal Years 1987-1991 (Washington, D.C.: 1986), pp. xxi, 64.

[21]CBO, The Economic and Budget Outlook: An Update (Washington, D.C.: Aug. 1986), p. XV.

as other domestic programs over the past several years, because of their size they may be subject to future changes in budget policy.[22]

Also, financing problems in the Medicare program have drawn attention to the possibility of reducing health care assistance to the elderly. Despite recent efforts by the administration and the Congress (which have been successful in slowing spending growth), a March 1986 report by the Board of Trustees for Medicare's Hospital Insurance (HI) Trust Fund reported that "the present financing schedule for the hospital insurance program is barely sufficient to ensure payment of benefits and maintain the fund at a level of one-half year's disbursements over the next 7 to 9 years if the assumptions underlying the estimates are realized."[23]

Objectives, Scope, and Methodology

Due to the issues described above, programs for the population age 65 and older, specifically health care programs, could come under increasing review over the next several years. As a result, the chairman of the Intergovernmental Relations and Human Resources Subcommittee of the House Committee on Government Operations in March 1986 asked us to provide information on:

1. current and projected demographic changes in the elderly population,

2. the relationship of these changes to

- the retirement income status of the elderly and
- their need, use, and expenditures for acute health care and long-term care services, and

3. the extent to which potential changes to federal health and retirement programs could affect the current and future needs of the elderly.

In conducting this study, we reviewed and analyzed data from existing studies, reports, congressional hearings, periodicals, and books. We also interviewed representatives from the academic community, gerontologists, researchers, and representatives from special interest groups concerned with the aging.

[22]Palmer and Torrey, p. 121. See also Marilyn Moon, "Impact of the Reagan Years on the Distribution of Income of the Elderly," The Gerontologist, Vol. 26, No. 1, 1986, pp. 32-37.

[23]Federal Hospital Insurance Trust Fund, Board of Trustees, The 1986 Annual Report of the Board (Washington, D.C.: Mar. 1986), p. 11.

To supplement the documentation on trends among the elderly and related issues, we interviewed federal officials from the Department of Commerce, Bureau of the Census; HHS, Health Care Financing Administration (HCFA), National Institutes of Health, National Institute on Aging, National Center for Health Statistics, Administration on Aging, and Social Security Administration; Office of Management and Budget; and National Academy of Sciences. In accordance with the requester's wishes, we did not request official agency comments on a draft of this report.

Retirement Income Status of Elderly Improved, but Several Groups Still Poor

Overall, the incomes of the elderly have risen substantially in recent years. In spite of this improvement, however, in 1984, 3.3 million elderly individuals still had incomes below the poverty level. Also, another 2.4 million elderly had incomes between the poverty line and 125 percent of the poverty line. A disproportionate number of women, minorities, and individuals age 85 and older are represented among these elderly poor.

Much of the improvement in the economic status of the elderly has been due to the growth in Social Security and public and private retirement benefits. Reductions in public programs could offset the economic gains many elderly have made.

Improved Economic Status of Elderly Largely Due to More Public Support

Between 1969 and 1984, average income increased by 18 percent for elderly families and 34 percent for elderly individuals, after adjusting for inflation.[1] During this time, the income status of the elderly improved substantially due to a general increase in income and improvements in Social Security benefits (particularly benefit increases between 1969 and 1972), and employer-sponsored pensions.[2]

In the late 1970's and early 1980's, economic stagnation slowed real income growth for most age groups, but real income for the elderly rose slowly during this time because automatic Social Security cost-of-living adjustments, which began in 1975, kept the real income of retired elderly from declining. Also, elderly who retired during that time had lifetime earnings records and thus higher benefits than those who had previously retired.[3]

This increase in the income of individuals age 65 and older meant that a smaller proportion of the nation's elderly were in poverty in 1984 than in the late 1960's. In fact, the poverty rate for the elderly was cut nearly

[1]Elderly families consist of families composed of two or more people that include at least one person age 65 or older; elderly individuals are people 65 or older living alone or with nonrelatives. (Nancy Gordon, CBO, Statement before the House Subcommittee on Health and the Environment, Committee on Energy and Commerce, Mar. 26, 1986, pp. 2-4.)

[2]U.S. Senate, Special Committee on Aging, Aging America: Trends and Projections (1985-6 ed.), (Washington, D.C.: GPO, 1986), pp. 54-56.

[3]U.S. Senate, Special Committee on Aging.

in half, from 25.3 percent in 1969 to 12.4 percent in 1984. In comparison, the rest of the population experienced an increase in poverty from 10.7 to 14.7 percent during this time frame.[4]

More elderly, however, remain near the poverty level than do other age groups. In 1984, almost 30 percent of all persons over 64 were in households below 1.5 times the poverty threshold (compared to 24 percent for persons 64 and younger). In addition, 43 percent of the elderly had incomes less than twice the poverty cutoff (compared with 35 percent for the nonelderly population).[5]

Support Shifted From Individual Resources to Public Programs

The improved economic status of the elderly results from a shift in retirement income support, primarily from reliance on individual resources to public programs. Prior to the 1960's, the elderly depended to a greater extent on income from earnings, families, or charities. Since then, such public programs as Social Security, Medicare, and SSI have become critical to the retirement income status of the elderly.

As public programs providing support to the elderly have expanded, there has been a corresponding decline in their earnings from employment. This is due in part to economic conditions, improved retirement benefits, and financial incentives and policies in Social Security and employer-sponsored pension plans, which encourage individuals to retire at age 65 or younger.

In fact, the number of the elderly in the labor force has dropped dramatically. In 1950, nearly one-half of all men 65 and older were in the labor force. By 1980, that percentage had been more than cut in half with about one-fifth of elderly men in the labor force. Among women 65 and older, labor force participation remained stable during those years—

[4]In 1984, the poverty threshold for a one-person household was $4,979 for people age 65 or older; for two-person households, the threshold was $6,282 for those headed by an elderly person (Gordon, pp. 2-4). Depending on which valuation method is used, estimates are that in 1983 the poverty rate among the elderly would have been reduced between 40 and 80 percent if in-kind benefits (such as food stamps, Medicaid, Medicare, and public housing programs) were counted. See Bureau of the Census, Estimates of Poverty Including the Value of Noncash Benefits; 1984 (Washington, D.C.: GPO, 1985), p. 7.

[5]Quinn, Joseph F., "The Economic Status of the Elderly: Beware of the Mean," to be published in a forthcoming issue of the Review of Income and Wealth.

only about 1 in 10 were employed. In 1985, about 1 of every 6 elderly men and 1 of every 14 elderly women were in the labor force.[6]

There also has been an increasing trend to retire before age 65. Men's labor force participation rates at age 60 to 64 declined from 80 percent in 1960 to 57 percent in 1984. In the 1960's the participation rate for men age 55 to 59 also declined, from 92 percent in 1960 to 81 percent in 1983. The rate for men age 50 to 54 also showed some decline from 95 percent in 1960 to 89 percent in 1983.[7]

Among women, the early retirement trend is less clear. Women with long-term jobs may be leaving the labor force earlier, but any such trend has been largely offset by increasing labor market entry. Even so, the labor force participation of women age 60 to 64 declined slightly in the 1970's from 36 percent in 1970 to 34 percent in 1983, while that of women age 55 to 59 grew much more slowly than in the past.[8]

Income Levels Among Elderly Widely Varied

The distribution of income levels among the elderly is extensive. In 1984, 20 percent of elderly couples had incomes of $30,100 and above, and 20 percent of elderly individuals had incomes of $13,700 or more. At the other end of the distribution, one in five couples had less than $10,100 in income, and one in five individuals had less than $4,200 (see table 2.1).

Table 2.1: Income of the Elderly (1984)

	Range of income	
Quintile (in percents)	**Couples**	**Individuals**
Lowest 20	Less than $10,000	Less than $4,200
20-39	$10,100–14,449	$4,200–5,799
40-59	14,450–20,099	5,800–8,049
60-79	20,100–30,099	8,050–13,699
80-100	30,100 and up	13,700 and up

Source: CBO calculations based on the Current Population Survey, Mar. 1985.

[6]U.S. General Accounting Office (GAO), Retirement Before Age 65: Trends, Costs, and National Issues (GAO/HRD-86-86, July 1986), p. 14. See also HHS, Social Security Administration, Office of the Actuary, Economic Projections for OASDI Cost and Income Estimates, 1984, Study No. 94, Jan. 1985, pp. 73-74.

[7]GAO, p. 14.

[8]GAO, p. 14.

This disparity could grow larger in the future. As described below, Social Security and public assistance represent nearly three-fourths of the income of those elderly below twice the poverty line and only about one-fifth of the income of those whose incomes exceed three times the poverty line. The elderly with higher incomes depend mostly on income from assets, earnings, and employer-sponsored pensions.[9] If the rate of growth in Social Security benefits and public assistance is lower in the future, it is likely that income for low-income elderly will not grow as fast as income for higher income groups. As a result, the income gap between the two groups could expand.[10]

Sources of Income Vary by Income Status

For most elderly, their economic status is determined in large part by their past involvement in the work force, the amount of assets they accumulated, their private pension coverage, whether they own their home, and how much it is worth.[11] Overall, the elderly receive 40 percent of their total income from Social Security, 22 percent from assets, 19 percent from earnings, 7 percent from private pensions, 7 percent from public pensions, 1 percent from public assistance, and 4 percent from other sources.[12]

Heavy Reliance on Public Income Programs Found

In 1984, there was substantial reliance by the elderly on such public income security programs as Social Security and SSI, particularly among those whose income fell at the bottom or middle of the income scale. Among elderly individuals, the proportion of income from public programs ranged from 93 and 89 percent for the two lowest income groups to 22 percent for the highest income group. Among couples, the proportion from public programs ranged from 86 and 70 percent for the two lowest income groups to 18 percent for the highest income group (see table 2.2).[13]

[9]Gordon, p. 11.

[10]Palmer, John L., and Stephanie G. Gould, "The Economic Consequences of an Aging Society," Daedalus, Vol. 115, No. 1, Winter 1986, p. 317.

[11]Streib, Gordon F., "Social Stratification and Aging," Handbook of Aging and the Social Sciences (2nd ed.), Robert H. Binstock and Ethel Shanas (ed.) (New York: Van Nostrand Reinhold Co., 1985), p. 339.

[12]Chen, Yung-Ping, "Economic Status of the Aging," Handbook of Aging and the Social Sciences (2nd ed.), Robert H. Binstock and Ethel Shanas (ed.) (New York: Van Nostrand Reinhold Co., 1985), pp. 653-654.

[13]Gordon.

Table 2.2: Elderly Income From Public Programs by Income Group (1984)

Income group (quintile in percents)	Percent from public programs[a]	
	Couples	Individuals
Lowest 20	86	93
20-39	70	89
40-59	56	77
60-79	37	53
80-100	18	22

[a]Includes Social Security and means-tested transfers.

Source: CBO calculations based on the Current Population Survey, Mar. 1985.

The program that provided the most support for the elderly with the lowest incomes was Social Security. Among couples, Social Security represented 82 percent of income for those with the lowest income and 18 percent for the highest income group. Among individuals, Social Security's share was 75 percent for those in the lowest income group and 22 percent for the highest (see table 2.3). By comparison, for the highest income groups, assets were the most important source of income with 38 percent of the income for couples coming from assets and 49 percent for individuals coming from assets (see figs. 2.1 and 2.2).[14]

Table 2.3: Comparison of Sources of Income Between High- and Low-Income Elderly (1984)

Source	Percent of total income			
	Couples		Individuals	
	Less than $10,100	$30,100 and up	Less than $4,200	$13,700 and up
Social Security	82	18	75	22
Pension	5	17	1	16
Income from assets	6	38	3	49
Earnings	2	26	1	12
Means-tested cash transfer	3	0	18	0
Other	2	1	2	1
Total	**100**	**100**	**100**	**100**

Source: CBO calculations based on the Current Population Survey, Mar. 1985.

[14]Gordon.

Figure 2.1: Source of Elderly Couple Income by Income Level (1984)

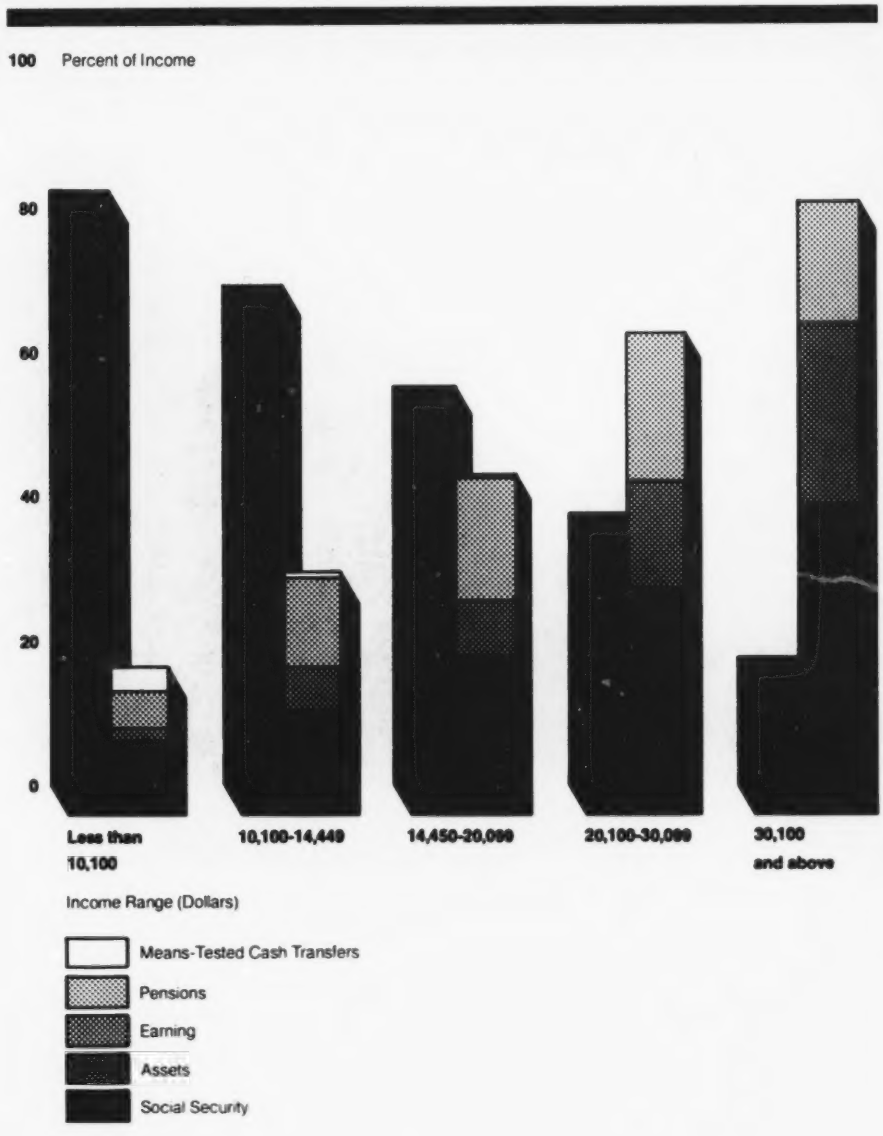
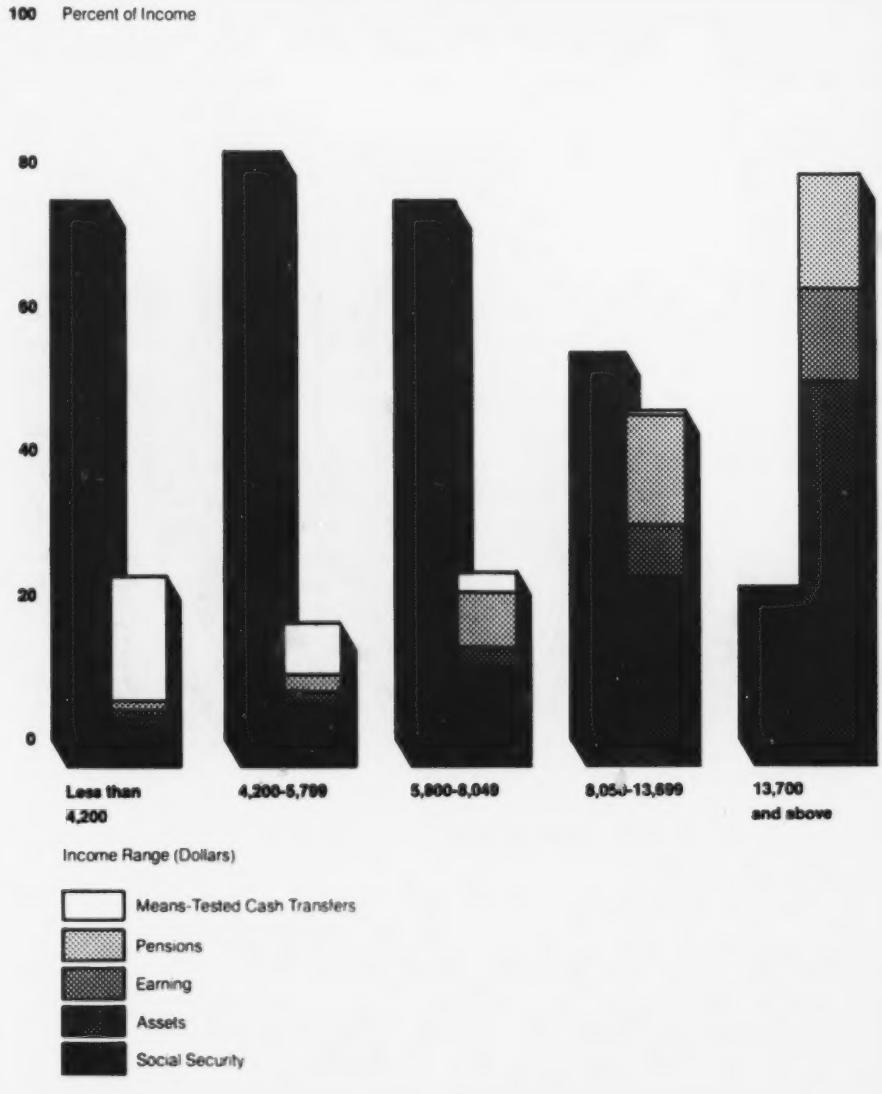


Figure 2.2: Source of Elderly Individual Income by Income Level (1984)



With respect to the net worth of the elderly, findings from a 1984 Bureau of the Census survey of income and program participation show variability in distribution (see table 2.4). Net worth is defined as the

value of assets covered in the survey less any debts (either unsecured or secured by assets).[15]

Table 2.4: Distribution of Net Worth Among the Elderly (1984)

Net worth	Population age 65 and older (percent)
0 to $4,999	15.4
$5,000 to 9,999	4.0
10,000 to 24,999	9.1
25,000 to 49,999	15.5
50,000 to 99,999	24.7
100,000 or more	31.3
	100.0

Source: Bureau of the Census, Data from the Survey of Income and Program Participation.

Support From SSI Available to Low-Income Elderly

For low-income individuals, means-tested cash transfers from SSI were important sources of income, but less so for couples. SSI benefits accounted for 18 percent of the income for the group of lowest income individuals and 3 percent for the lowest income couples.[16]

Not all elderly poor are eligible for these benefits. Enacted in 1972 as an amendment to title XVI of the Social Security Act, SSI is a federally funded program that provides a guaranteed minimum income to the elderly, blind, and disabled if their income falls below federal poverty standards and their assets do not exceed specific eligibility criteria.[17]

Even when individuals qualify for public means-tested benefits, reliance on these programs often means subsisting at an income level below the poverty line. In 1984, despite a recent increase in federal basic benefits paid by SSI, those benefits were 75 percent of the poverty threshold income for individuals and 90 percent for couples. Only 4 states provided state supplements to SSI large enough to bring the total benefit

[15]Bureau of the Census, Household Wealth and Asset Ownership: 1984 Data from the Survey of Income and Program Participation (Washington, D.C.: GPO, July 1986), pp. 18-19. Assets covered include interest-earning assets, stocks mutual fund shares, real estate (own home, rental property, vacation homes, and land holdings), own business or profession, mortgages held by sellers, and motor vehicles.

[16]Gordon.

[17]U.S. Senate, Special Committee on Aging, The Supplemental Security Income Program: A 10-Year Overview (Washington, D.C.: GPO, May 1984), pp. 15, 18, 19, 47, and 48.

above the poverty threshold for individuals, and only 11 states provided enough to bring couples above the poverty line.[18]

Certain Groups of Elderly Remain Poor

Poverty among the elderly is centered in certain subgroups that make up a large portion of the poor elderly population. Three such groups are women, minorities, and the oldest elderly (those 85 and older). In 1984, 3.3 million or 12.4 percent of the elderly had incomes below the poverty level. Of these individuals with low incomes:

- For women, the poverty rate was nearly twice the rate for men,
- Among black elderly, the poverty rate was nearly three times the rate for white elderly, and
- Persons 85 and older were twice as likely to be living below the poverty line as persons 65-74.[19]

Women Are 70 Percent of Elderly Poor

In 1984, the number of elderly women in poverty totaled 2.4 million or 71.2 percent of the elderly poor, a proportion much higher than their 58.9 percent of the total elderly population. Although the poverty rate for elderly women has been reduced considerably in the last two decades, it is still considerably higher than the rate for men. In 1984, the poverty rate for elderly women (15 percent) was nearly twice the rate for men (8.7 percent).[20]

The low economic status of elderly women stems from the fact that in the past many women did not participate in the labor force or had intermittent patterns of employment or short job tenure. Of those women who did hold jobs, many were in occupations typically not covered by employer-sponsored pension plans. If they did work where they were covered by a pension plan, they may not have stayed in one job long enough to have become vested or eligible for retirement benefits.

Due to these different factors, pension receipt for women is much less than for men; this is also true for minorities, who have lower pension income than whites. In 1983, white elderly men constituted the group most likely to be receiving a pension and were four times as likely as

[18]U.S. House of Representatives, Committee on Ways and Means, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means (Washington, D.C.: GPO, Mar. 3, 1986), pp. 77-78.

[19]U.S. House of Representatives, Committee on Ways and Means, p. 77.

[20]U.S. House of Representatives, Committee on Ways and Means.

black elderly women to be pensioned. In this same year, among the elderly, 44 percent of white men were receiving income from a private pension, followed by black men (24 percent), white women (21 percent), and black women (11 percent).[21]

Because women tend to live longer than men, they are also vulnerable to becoming poor after the death of a spouse or divorce. Among the reasons their income is lower are:

- Social Security benefits paid to a surviving spouse are typically two-thirds of the amount received previously by the couple.
- Women who are divorced, if their marriage did not last 10 years, cannot receive a dependent spouse's Social Security benefits.[22]
- Private pension annuities may have been forfeited in the absence of joint-and-survivor benefits.[23]
- If the deceased spouse had been employed, the surviving spouse loses the earned income.[24]

Black Elderly Three Times as Likely to Be Poor as White

Although poverty among black elderly has been reduced considerably in the last two decades, their poverty rate is much larger than the rate for whites. In 1966, the poverty rate among elderly black men was 52 percent and among elderly black women 57 percent. By 1984, the rates had been reduced to 26 percent among the men and 36 percent for the women. Overall, however, the 1984 rates were still nearly three times that for white elderly (31.7 percent among blacks versus 10.7 percent among whites).[25]

For both married and single persons, the income of elderly blacks was lower than the income of elderly whites. The median income of black

[21]GAO, p. 25.

[22]Atkins, G. Lawrence, "The Economic Status of the Oldest Old," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, 1985, p. 402, and U.S. Senate, Special Committee on Aging, Developments in Aging: 1985, Vol. 1 (Washington, D.C.: GPO, 1986), p. 22.

[23]If a joint-and-survivor annuity is elected at the time of retirement, the retiree receives lower monthly benefits. If the retiree dies, the spouse will continue to receive benefits often at a further reduced level. The most recent data available show that 58 percent of married men and 32 percent of married women who retired between June 1980 and May 1981 and were receiving a pension opted to receive joint-and-survivor benefits.

[24]Atkins.

[25]U.S. House of Representatives, Committee on Ways and Means.

couples was 60 percent of that of white couples, and black single individuals had median incomes equal to 70 percent of the median income of white single individuals.[26]

The reasons for the lower incomes among blacks were similar to those for women. They were less likely to have had jobs covered by private pensions and, even if they did, were less likely to have accumulated pension rights because of shorter job tenure or lack of continuous employment.[27]

Of Those 85 and Older, 20 Percent in Poverty

Economically, the 85 and older group, which is nearly 70 percent female,[28] is worse off than the younger elderly. In 1983, elderly families 85 and older had a median income only two-thirds as large as the families in the 65-to-74 age group. For individuals, those 85 and older had a little less than 80 percent of the median income of individuals in the 65-to-74 age group.[29]

More than one in every five people (21.3 percent) age 85 and older were in poverty in 1983, compared to about 11.9 percent of the 65-74 group and 16.7 percent of the 75-to-84 age group. Another 22.4 percent of the 85 and older group had incomes between the poverty line and 150 percent of the poverty line, compared with about 13.4 percent of the 65-to-74 age group and 20.2 percent of the 75-to-84 group.[30]

Compared with the younger groups, the elderly 85 and older were more likely to have lost a spouse and the income of that spouse and thus were more likely to be poor. Of all persons 85 and older, 75 percent were widowed.[31] Unrelated individuals, who tended to be older than the elderly

[26]Chen, p. 664.

[27]Chen.

[28]Longino, Charles F., Jr., The Oldest Americans: State Profiles for Data-Based Planning, Center for Social Research in Aging, University of Miami (Miami, Fla.: June 1986) (a final report for the Andrus Foundation).

[29]U.S. Senate, Special Committee on Aging, Aging American, p. 45.

[30]Longino; see also Atkins, p. 398.

[31]U.S. Senate, Special Committee on Aging, Aging American, p. 50.

living in families, were also more likely to be female. An elderly unrelated individual was more than three times as likely to be living in poverty (24 percent) as an elderly person who lived in a family (7 percent).[32]

One explanation for the differences in income between the different age groups of elderly is that the younger elderly had higher incomes while employed and consequently higher retirement benefits. Also, maximum benefits under Social Security have increased, and the younger groups of elderly have benefited more from the improvements in employer-sponsored pension coverage that took place during the 1950's and early 1960's.

Economic Outlook for Elderly Difficult to Project

It is difficult to project the role that various income sources will play in the future for the elderly. If their labor force participation rates continue to decline, the importance of earnings may decline. Because few private pensions are automatically adjusted for inflation, the role of pensions for elderly who are already retired will be affected by future rates of inflation.[33] Also, pension coverage recently declined from 56 percent in 1979 to 52 percent in 1983.[34] If this decline continues, a smaller number of elderly (compared with those currently covered) could be eligible to receive pensions when they retire.

Current projections show both Social Security and private pensions increasing through the year 2020 for both men and women.[35] The largest increase among individuals 65 and older is expected in average Social Security payments to men age 68 to 71, who could expect an increase from an average of $4,972 in 1982 to $7,831 in the year 2020 (in constant 1980 dollars).[36]

[32]Atkins.

[33]In 1981, only 3 percent of full-time workers were in pension plans that provided for automatic increases in pension benefits to compensate for rises in the cost-of-living. See Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1981 (Washington, D.C.: GPO, Aug. 1982), pp. 8-9. However, postretirement benefit increases are frequently provided on an ad hoc basis. Emily Andrews, The Changing Profile of Pensions in America (Washington, D.C.: Employee Benefits Research Institute, 1985), pp. 123-124.

[34]Andrews, p. xvii.

[35]Zedlewski, Sheila R., "The Private Pension System to the Year 2020," Retirement and Economic Behavior, Henry Aaron and Gary Burtless, eds. (Washington, D.C.: The Brookings Institution, 1984), pp. 326-327.

[36]Reno, Virginia P., et al., p. 26.

The incomes of elderly blacks are projected to remain low relative to elderly whites. This is because blacks are projected to hold lower paying jobs not covered by private pension plans and to be less likely to accumulate pension rights because of shorter tenure or a lack of continuous employment.[37] The future economic picture for the fastest growing segment of the elderly population, the group 85 and older, is seen as one of gradual improvement in the next two decades due to the movement of the current more affluent elderly into that age bracket. This improvement may be short lived, however, as behind them may be individuals who are economically no better off.[38]

[37]Chen, p. 664.

[38]Atkins, p. 417.

High Cost of Acute Medical Care Is a Major Problem for Some Elderly

While the overall economic well-being of the elderly has improved significantly over the past decades, the rising costs of health care pose a major threat for some individuals. In particular, high out-of-pocket health costs can deter those elderly whose incomes have remained below or near the poverty level from obtaining care.

Such out-of-pocket health expenses could increase in the future as a result of measures to reduce the costs of Medicare's Hospital Insurance program. In spite of recent successes in cutting program costs, the HI trust fund is projected to be depleted in the late 1990's.

Because the elderly are at greater risk of needing health care resources than are individuals younger than 65, the aging of the population is likely to result in higher national health care utilization. The resulting increase in expenditures will add to the problems some elderly already experience in paying for health care.

Health Care Utilization Increases With Age

When judged on three measures of health status—perceived health status, days confined to bed (due to illness), and limitation of activity—the majority of the elderly living in the community in 1984 were in good health, according to preliminary data from HHS's National Health Interview Survey. [1] But despite this positive assessment, the elderly are at much greater risk of needing health care resources than are individuals under 65. As a result, the elderly use more health services and have higher health care expenditures.

For instance, individuals 65 and older use more hospital care than does the general population. Although in the last 2 years total admissions in short-stay hospitals for the elderly have decreased, their hospital utilization from 1965 to 1983 increased 50 percent compared with a 10-percent increase for the total population.[2] Over the past decade, surgical admissions of patients 65 and older increased 106 percent, compared with a 49-percent increase for all surgical patients.[3]

[1]Kovar, M. G., "Aging in the Eighties/Preliminary Data from the Supplement on Aging to the National Health Interview Survey United States, January-June 1984," HHS, National Center for Health Statistics, Advance Data, No. 115, May 1, 1986, p. 5.

[2]Medicare became effective July 1, 1966. U.S. Senate, Special Committee on Aging, Aging America: Trends and Projections, 1985 (Washington, D.C.: GPO, 1986), p. 99.

[3]National Center for Health Services, Research and Health Care Technology Assessment, "Surgical Mortality Drops for the Elderly Despite Admissions Rise," Research Activities, No. 79, Nov. 1985, p. 1.

Use of physician services also increases with the patient's age. In 1983, individuals age 45-64 averaged 6.1 doctor visits a year compared with 7.4 visits for persons age 65-74. Overall, persons 65 and older visit a physician eight times for every five visits by the general population.[4] Use of other health care services (except dental care) also increases with age. For prescription drugs, vision aids, and medical equipment and supplies, the elderly have higher rates of utilization than does the younger population.[5]

Within the elderly population as well, health care utilization increases with age. For example, in 1983 the elderly, representing 12 percent of the population, accounted for 29 percent of all hospital discharges. Individuals 75 and over (4.4 percent of the population) accounted for 15.1 percent of all hospital days. Also, the rate of hospital days per 1,000 individuals age 85 and older was almost twice that of the 65-to-69 age group.[6] In 1984, of those elderly living in the community, 18 percent age 65 to 74 had been hospitalized during the year, compared with 25 percent of those age 85 and older.[7]

Since the elderly (particularly the oldest) are the highest users of health care, the growth in the population age 65 and older is certain to further increase utilization.[8] Also, adding to the rate of projected growth in the demand for health care are medical advances that have resulted in better diagnoses and treatment of diseases that affect the elderly. These advances have consequently increased demands for services.[9]

In light of technological advances, biomedical breakthroughs, and healthier life styles, however, future projections of increased health care utilization may need to be modified. All these factors could help prevent or control some diseases or illness, which could reduce the future need

[4]U.S. Senate, Special Committee on Aging, pp. 99, 101.

[5]U.S. Senate, Special Committee on Aging, p. 102.

[6]U.S. Senate, Special Committee on Aging.

[7]Kovar, p. 5.

[8]As an example, according to projections based on physician visit rates for 1980 and Census Bureau population projections, the total number of physician visits by the elderly is projected to increase by 47 percent from 1980 to the year 2000. See U.S. Senate, Special Committee on Aging, p. 102.

[9]Waldo, Daniel R., and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the U.S.: 1977-1984," Health Care Financing Review, Fall, 1984, Vol. 6, No. 1, p. 27.

for care, particularly institutional care.[10] On the other hand, some studies predict that the increased life span of the oldest elderly could result in dramatic increases in the need for health services. This would be consistent with trends over the past 20 years, which show declining mortality rates and rising morbidity for middle-age and older persons.[11]

Health Care Expenditures for Elderly Rising Rapidly

The increase in health care utilization due to the growth in the elderly population also will have an effect on the nation's total health care expenditures, which are already high. In fact, spending for personal health care for the elderly has almost tripled—increasing from $43 billion in 1977 to a projected $120 billion in 1984. In that year, persons age 65 and over accounted for one-third of all personal health care expenditures nationally.[12]

Public programs financed two-thirds of the 1984 personal health care expenditures for the elderly. Medicare, which provides health insurance benefits for most individuals age 65 and older, pays almost half of the elderly's total health bill.[13] Implemented in 1966 under title XVIII of the Social Security Act, Medicare comprises the Hospital Insurance Program and the Supplementary Medical Insurance Program. Medicare has a uniform eligibility and benefit structure and makes protection available to insured persons without regard to their income or assets.[14]

Medicaid, which represents the other large government source of funds for personal health care, is a federal/state program that paid about 13 percent of the elderly's total expenditures for care (primarily for nursing home care). Established in 1966 under title XIX of the Social Security Act, Medicaid provides medical assistance to certain categories of low-income persons, including the aged. In recent years, the number of Medicaid recipients age 65 and over was estimated to range from 3.5 to 4 million, most of whom were also enrolled in Medicare. In 1984, it

[10]Davis, Karen, "Aging and the Health Care System: Economic and Structural Issues," Daedalus, Journal of the American Academy of Arts and Sciences, Winter, 1986, pp. 236, 240.

[11]Rowe, John W., "Medical Progress - Health Care of the Elderly," The New England Journal of Medicine, Vol. 312, No. 13, Mar. 28, 1985, p. 828. Dorothy P. Rice, "Living Longer in the United States: Health, Social and Economic Implications," The Journal of Medical Practice Management, Vol. 1, No. 3, pp. 164-165.

[12]Waldo, Daniel R., and Helen C. Lazenby, p. 8., and U.S. Senate, Special Committee on Aging, Aging America: Trends and Projections, 1985, p. 103.

[13]Waldo and Lazenby, p. 1.

[14]O'Sullivan, Jennifer, Medicare: FY 86 Budget, Congressional Research Service, Jan. 24, 1986, p. 1.

was estimated that state and federal Medicaid expenditures for the elderly totaled $15.3 billion. [15]

Other government programs, primarily those of the Veterans Administration (VA), paid about $3.3 billion in health expenditures for the elderly in 1984. The VA health care system provides care through its hospital centers, outpatient clinics, and VA-operated and community nursing homes.[16] Over the next 20 years, the cost of VA health care is projected to rise dramatically because the average age of veterans will increase significantly.[17]

Some Elderly Face High Out-of-Pocket Costs

Increasing health care costs represent a growing problem for the elderly—particularly the elderly poor. Even with substantial federal spending, one-third of health spending for persons 65 and older is paid for by the elderly themselves or their families, either in the form of direct payments to service providers or as premiums for insurance.[18]

Some of this out-of-pocket spending results because the beneficiary is required to pay coinsurance and deductibles for Medicare-covered services. In other cases, it is due to expenditures for services not covered by Medicare. Medicare does not cover dental care, prescription drugs, eyeglasses, hearing aids, or routine or preventive medical care. Also, because Medicare coverage primarily is aimed at acute care, older Americans are at risk for significant long-term care expenses.[19]

For 1987, enrollees' financial risk for Medicare-covered services is projected to be on average $700. These expenses could range from $250 (for the 34 percent of enrollees who will use no reimbursable services but will pay Medicare premiums) to $14,270 for the one-fifth of 1 percent of the elderly who will have hospital stays long enough to draw on their

[15]Waldo and Lazenby, pp. 23-24.

[16]Waldo and Lazenby, p. 24.

[17]VA, Caring for the Older Veteran (Washington, D.C.: GPO, July 1984), pp. I-14, II-10.

[18]Gordon, Nancy M., CBO, Statement before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, Mar. 26, 1986, p. 13.

[19]HHS, HCFA, Office of Research and Demonstrations, Medicare and Medicaid Data Book, 1984 (Health Care Financing Program Statistics) (Baltimore, Md.: June 1986), p. 5.

lifetime reserves. Older enrollees are especially likely to face high personal financial liabilities because a greater percentage of the population 85 and older has multiple hospital admissions. [20]

Also, Medicare's inpatient deductible has increased because the average length of stay under Medicare's new hospital Prospective Payment System (PPS) has dropped. Because the inpatient deductible is based on the average Medicare cost per day, the effect of short stays has been an increase in the deductible from $400 in 1985 to $492 in 1986. This increase will cost beneficiaries about $550 million in additional health care costs in 1986.[21] HHS projections show that the average cost for a hospital day could rise 16 percent in 1986, which could increase the 1987 Medicare deductible patients would have to pay in 1987 to $572.

Problems in Funding Retirees' Health Benefits

In 1984, 80 percent of the elderly (or over 20 million) were covered by either private supplemental insurance (commonly called Medigap insurance) or Medicaid in addition to being covered under Medicare. Two million, or 8 percent of these elderly, were eligible for Medicaid. About 72 percent (18 million) had purchased some form of private supplemental insurance (either as part of a group—generally through a current or former employer or union—or an individual policy) to protect themselves against out-of-pocket health costs not covered by Medicare.[22] Most elderly purchase some type of Medigap policy which covers part or all of Medicare deductible and coinsurance amounts. While these policies reduce some of the risks of catastrophic out-of-pocket costs, they generally do not broaden the range of services covered. For these policies, the elderly also incur premium costs, which averaged $300 to $400 per person in 1984.[23]

While some retirees buy individual supplemental insurance policies, others are covered by insurance paid for by their former employers. These health insurance plans typically provide coverage for retirees not

[20]Under the HI portion of Medicare, hospitalized beneficiaries pay a deductible amount for each spell of illness, coinsurance for inpatient days 61 through 90, and for each of the 60 lifetime reserve inpatient days. Gordon, pp. 15-16.

[21]Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System (Washington, D.C.: Feb. 1986), p. 5.

[22]These estimates are based on the noninstitutionalized elderly and do not include the institutionalized elderly, many of whom are covered by Medicaid. Gordon, pp. 16, 18, 20.

[23]Gordon, p. 20.

yet eligible for Medicare (because they are under age 65) or supplement Medicare benefits for retirees age 65 and older.[24]

According to a study by the Department of Labor, in 1985 private sector employers paid an estimated $4.6 billion to provide coverage for retirees and their spouses and dependents. These plans, which cover an estimated 16 percent of the population over age 65, significantly reduce out-of-pocket health costs; most, however, do not cover long-term care.[25]

The costs for funding retirees' health benefits have escalated because of the trend over the last decade for individuals to retire early and the increasing size of many companies' retiree populations. As a result, many employers have subsequently attempted to eliminate or cut back benefits; until recently, court rulings have limited employers' rights to alter health benefits for those already retired.[26] There is also concern that these health benefits will be unavailable if the employer goes out of business or stops providing the coverage because of costs.

Additionally, there is no mechanism to insure that funds will be available in the future to pay benefits. Unlike the protection accorded most pension obligations, the law does not require that employers actuarially fund their future costs for health care benefits. According to Department of Labor estimates, the present value of the accrued liability for retiree health benefits is estimated to have been $98.1 billion in 1983.[27]

These unfunded liabilities could jeopardize the payment of benefits to future retirees; if this occurred, it would significantly increase out-of-pocket health care expenses for many elderly.

[24]Employee Benefit Research Institute, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," Issue Brief, No. 47, Oct. 1985, and Thomas D. Leavitt, "Corporate Retiree Health Benefits: An Emerging Issue," Of Current Interest, Brandeis University, Policy Center on Aging, Vol. 6, No. 1, Feb. 1986.

[25]Department of Labor, Pension and Welfare Benefits Administration, Office of Policy and Research, Employer-Sponsored Retiree Health Insurance, May 1986, pp. 1, 11-14.

[26]A recent decision by the Sixth Court of Appeals raises questions about the validity of these rulings. Roger J. Thomas, "Retiree Health and Hospitalization Benefits," Bifocal, Commission on Legal Problems of the Elderly, Vol. 7, No. 2, Summer 1986, p. 7.

[27]Department of Labor, Office of Policy and Research, p. 2.

One in Five Elderly Very Vulnerable to High Financial Risk

In 1984, about 5 million or 20 percent of the elderly had no protection other than Medicare against out-of-pocket health care costs. More critically, the elderly with lower incomes and the greatest health care needs are most likely to not have supplemental insurance.[28]

Even though health care needs rise with age, individuals 80 and older are less likely to have supplemental insurance. Of individuals 80 and older, an estimated 27 percent will be without supplemental coverage in 1987, compared with 17 percent of those between 65 and 69. And, while Medicaid covers many elderly likely to be in poor health, among the elderly not eligible for Medicaid, "those in poor health were least likely to have private insurance—28 percent were not covered, compared with 20 percent for those whose health was good or excellent."[29]

For those who have neither private supplemental insurance nor Medicaid eligibility, out-of-pocket expenditures are estimated to average $710 in 1987. In contrast, those elderly with private supplemental insurance are projected to spend an average of $940 out of pocket in 1987 for acute care. Because their use of medical care will be greater, they will spend more than individuals without supplemental insurance (individuals who must pay a share of the cost generally are discouraged from obtaining as much medical care as they might otherwise use); also, they will pay administrative costs for their Medigap policies. Their risks of extremely high expenditures, however, will be lower.[30]

The elderly poor and near poor not covered by supplemental insurance and ineligible for Medicaid are less likely to receive health services because they cannot afford high out-of-pocket costs. This was documented in a recent study that examined the effect of such costs on elderly whose income was less than 125 percent of the poverty line. The analysis compared levels of illness, use of health services, and out-of-pocket expenses for poor elderly who supplement Medicare coverage with public or private insurance and those who do not.[31]

The study found that the poor and near-poor elderly who rely on Medicare only use substantially fewer physician services, drugs, and hospital

[28]Gordon, p. 22.

[29]Gordon, pp. 21-23.

[30]Gordon, pp. 25-26.

[31]Berk, Marc L., and Gail R. Wilensky, "Health Care of the Poor Elderly: Supplementing Medicare," The Gerontologist, Vol. 25, No. 3, 1985, p. 311.

services than do other elderly who also have Medicaid or private health insurance coverage. This comparatively low level of utilization may be accounted for by the substantial out-of-pocket expense. In addition, elderly poor with private insurance did use more health services, but their ability to obtain health care appeared to carry a heavy financial burden.[32]

Medicare's Costs for Elderly Also Increasing

While the elderly are confronted with increasingly higher out-of-pocket costs, Medicare is also experiencing financing problems. Not only is it the nation's largest health financing program, but it is also one of the fastest growing programs in the federal budget. In 1983, Medicare expenditures of $59 billion represented 57 percent of total federal outlays for health care, compared with 40 percent in 1973. By 1990, Medicare is projected to represent 63 percent of federal health care expenditures.[33]

In 1985, benefit payments for Medicare increased 12.2 percent above 1984 levels, compared with an 8.9-percent increase in health care spending for the general population. Medicare spent $71 billion for health care benefits in 1985,[34] and projections show its annual expenditures rising to $131.5 billion by 1990. Also, the number of elderly covered by Medicare has increased from 23.8 million in 1977 to 28 million in fiscal year 1985.[35]

Of the total $71.4 billion in Medicare outlays for fiscal year 1985, $48.7 billion were for HI and $22.7 billion for SMI.[36] HI covers inpatient hospital care, posthospital care in a skilled nursing home, home health services, and hospice care for the terminally ill. SMI covers physicians' services and a range of other services, including outpatient hospital services, physical therapy, diagnostic and X-ray services, and durable medical

[32]Berk and Wilensky, pp. 313-314.

[33]Arnett, Ross H., III, et al., "Health Spending Trends in the 1980s: Adjusting to Financial Incentives," Health Care Financing Review, Spring 1985, Vol. 6, No. 3, p. 11.

[34]HHS, HCFA, Information obtained July 29, 1986, to be included in the Fall issue of Health Care Financing Review.

[35]Arnett, Ross H., III, et al., "Projections of Health Care Spending to 1990," Health Care Financing Review, Spring 1986, Vol. 7, No. 3, pp. 1-2.

[36]O'Sullivan, Jennifer, Medicare: Physician Payments (Washington, D.C.: Congressional Research Service, Mar. 7, 1986), p. 2.

equipment.[37] Both parts of Medicare have limits on services and such cost-sharing features as deductibles and copayments.[38]

In 1982, over 17 million elderly enrollees (641 out of every 1,000 enrolled) received services reimbursed under the Medicare program after meeting the program deductible. By 1984, this proportion had increased to an estimated 660 out of every 1,000 enrollees receiving reimbursed services.[39]

The use of Medicare-covered services varies by age. For example, in 1982, 733 of every 1,000 enrollees age 85 or over received reimbursed services, compared with 600 per 1,000 individuals age 65-74. The amount of reimbursement per user also varied by age, ranging from $2,200 for individuals 65-74 years of age to $3,000 for individuals 85 years and over.[40]

Hospital Insurance Program Projected to Be Out of Funds in the 1990's

The rise in Medicare costs has been a concern for several reasons. Medicare expenditures have become an increasingly larger proportion of federal spending, increasing from 4 percent in fiscal year 1976 to 7 percent in fiscal year 1985; they are projected to increase to 10 percent of the federal budget by 1988. As a result, high federal deficits have led to pressures to reduce Medicare expenditures.[41]

Another concern for Medicare is the projected insolvency in the HI trust fund. In its March 1986 report to the Congress, the Board of Trustees for HI reported that under intermediate assumptions the trust fund is projected to increase until about 1989, then decline until the fund is exhausted in the late 1990's. Under the more optimistic assumptions, it

[37]HHS, HCFA, Office of Research and Demonstrations, pp. 5, 40, 43-44.

[38]CBO, Physician Reimbursement Under Medicare: Options for Change (Washington, D.C.: Apr. 1986), p. 5. Medicare's copayment requirements in 1986 for the HI program included: a first-day deductible of $492 for hospital stays, coinsurance of at least $123 a day for hospital stays exceeding 60 days, and coinsurance of $61.50 a day for stays in skilled nursing homes exceeding 20 days. In SMI, there is a monthly premium ($15.50 in 1986), and individuals are responsible for 20 percent of all approved physicians' charges above an annual deductible amount ($75) and for 100 percent of any charges above Medicare's approved rates if their physicians do not accept assignment.

[39]Waldo and Lazenby, p. 15.

[40]Waldo and Lazenby, p. 19.

[41]Arnett, McKusick, Sonnefeld, and Cowell.

would remain solvent throughout the 25-year period (1986 to 2010); under the most pessimistic, the fund would be exhausted in 1993.[42]

In 1985, Medicare's HI component was financed primarily by the contributions of 122 million workers and their employers through payroll taxes.[43] The HI Program maintains a trust fund to provide a small reserve against fluctuations and respond to demographic changes in the population. In its report, the board noted that there were currently over four covered workers supporting each HI enrollee. By the middle of the 21st century, this ratio is expected to decline to slightly more than two covered workers supporting each enrollee. The report concluded that

"... not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change but also with the exception of the most optimistic assumptions, the HI trust fund is projected to be exhausted even before the major demographic shift begins to occur."[44]

There is substantial concern, therefore, that the current financing schedule is inadequate to assure Medicare's long-term health.

SMI's Increasing Cost Also a Problem

The increasing costs of the Medicare SMI program are also a problem. Financing for SMI is established annually on the basis of standard monthly premium rates and monthly actuarial rates determined separately for aged and disabled beneficiaries. Under current legislation, the monthly premium is set so that premiums comprise about 25 percent of SMI revenue needs for elderly beneficiaries during the year; the remainder is obtained from general revenues.[45]

In its 1986 report, the Board of Trustees noted concern over the cost of SMI and recommended that the Congress take action to curtail the rapid

[42]Board of Trustees, Federal Hospital Insurance Trust Fund, The 1986 Annual Report of the Board (Washington, D.C.: Mar. 1986), p. 4. Prior to the enactment of the Social Security Act Amendments of 1983 (Public Law 98-21), CBO had predicted that the HI fund could be exhausted as early as 1987. Tax changes and savings from changes in hospital payment policies included in Public Law 98-21, changes in subsequent legislation, and more optimistic assumptions about the future performance of the national economy subsequently have delayed the anticipated depletion of the trust fund to the 1990's. Julian Pettengill, Medicare: The Financing Problem in the Hospital Insurance Program (Congressional Research Service, Jan. 2, 1986), p. 11.

[43]Board of Trustees, Federal Hospital Insurance Trust Fund, p. 2.

[44]Board of Trustees, Federal Hospital Insurance Trust Fund, p. 11.

[45]O'Sullivan, Medicare: Physician Payments, p. 2.

growth of this program.[46] As an example of the problem, while total Medicare reimbursements per enrollee increased at an annual rate of 13.6 percent from 1975 through 1985 (more than twice the rate of economy-wide inflation), reimbursement per enrollee for SMI increased at an annual rate of 15.5 percent.[47]

In 1984, as an interim measure to control these costs, the Congress approved a 15-month freeze on physicians' fees; it was subsequently extended through December 1986. While reduced inflation and the fee freeze have slowed the rate of increase, however, payments under SMI still are expected to grow more rapidly than the rest of Medicare, at an annual rate of 14.7 percent from fiscal year 1986 through 1991.[48]

Initial Concerns About PPS Under Medicare

In response to the rapid escalation in hospital costs, the Congress in 1983 replaced Medicare's cost-based reimbursement system for inpatient hospital care with the prospective payment system, now being phased in. Under PPS, for each admission Medicare pays a rate predetermined on the basis of the patient's principal diagnosis and certain other factors. Each admission is assigned to one of 468 diagnosis related groups (DRGs) for payment.[49] PPS is intended to discourage extended inpatient stays and encourage the substitution of less expensive care outside of the hospital.[50]

While the average length of stay for Medicare patients had been declining over the past decade, the estimated length of stay for all Medicare short-stay hospital discharges in fiscal year 1984 was 9 percent lower than in fiscal year 1983. This represented the largest decline in the history of the program. In addition and unexpectedly, Medicare inpatient admissions declined by almost 5 percent; admissions also

[46]Board of Trustees, Federal Supplementary Insurance Trust Fund, The 1986 Annual Report of the Board (Washington, D.C.: Mar. 1986), p. 7.

[47]CBO, p. XV.

[48]CBO, p. 1.

[49]Office of Technology Assessment, Medicare's Prospective Payment System—Strategies for Evaluating Cost, Quality and Medical Technology (Washington, D.C.: GPO, Oct. 1985), pp. 3, 5. The phase-in of PPS began in October 1983 and will be completed by October 1987.

[50]Office of Technology Assessment, pp. 24-25.

appear to have dropped by an even larger percentage in 1985. Earlier discharges from hospitals are believed to be a consequence of PPS.[51]

The decline in average length of stay under PPS has increased demand for postdischarge services. Testimony by GAO, the Office of Technology Assessment, and the Prospective Payment Commission before the Senate Finance Committee in June 1986 raised concerns regarding the discharge of some patients sooner and in poorer states of health than before PPS.[52]

Quality is also a potential concern under the new reimbursement system. PPS removed the financial incentives to provide more Medicare-covered services than needed in hospital settings.[53] As a result

"Hospitals now stand to gain the most by curtailing both services and days of hospital care whenever possible. Under this system, hospitals can profit financially from cutting back on medically appropriate, as well as inappropriate, services. Thus, the discharging of patients still in need of hospital care has become a primary quality concern under PPS."[54]

Proposals Made to Contain Medicare's Costs

For the past several years, the Congress and the administration have focused on addressing Medicare's financing problems through cost containment initiatives that have reduced payments to hospitals and physicians, increased beneficiary cost-sharing, and in certain circumstances shifted the cost of services to other sources of payment.[55] The establishment of PPS, along with a slowing rate of inflation in medical care, has reduced some of the pressure on the HI trust fund. Also, legislation enacted between 1981 and 1985 will reduce the Medicare budget by $23.5 billion by the end of 1987.

[51]HHS, HCFA, Office of Research and Demonstrations, Impact of the Medicare Hospital Prospective Payment System (Aug. 1986), p. viii, and Prospective Payment Assessment Commission, p. 3.

[52]Statements of Eleanor Chelimsky, GAO, Judith Wagner, Office of Technology Assessment, and Donald A. Young, Prospective Payment Assessment Commission, on "Quality of Care Issues in the Medicare Program" before the U.S. Senate, Committee on Finance, June 3, 1986.

[53]Guterman, Stuart, and Allen Dobson, "Impact of the Medicare Prospective Payment System for Hospitals," Health Care Financing Review, Spring 1986, Vol. 7, No. 3, pp. 97-99, and Prospective Payment Assessment Commission, pp. 60-71.

[54]Chelimsky, p. 3.

[55]Iglehart, John K., "Health Policy Report—Early Experience with Prospective Payment of Hospitals," The New England Journal of Medicine, Vol. 314, No. 22, May 29, 1986, p. 1460, and Pettengill, p. 22.

The administration's fiscal year 1987 budget, submitted to the Congress in February 1986, reflects the continuing theme of constraining spending. It includes numerous regulatory and legislative proposals to reduce Medicare outlays by almost $5 billion in fiscal year 1987. These spending reductions would come chiefly from providers of care through a lower-than-inflation increase in payments to hospitals, a new prospective payment system for capital payments to hospitals, reductions in special payments to teaching hospitals, and reductions in payments to physicians. Also, some costs would be shifted to beneficiaries through increases in beneficiary premiums and deductibles and new patient charges for home health services.[56]

One administration proposal, which would establish a copayment on the first 100 home health visits in a year, is projected to reduce outlays by $100 million in fiscal year 1987 and $640 million over the period fiscal years 1987-91. It is estimated that, if a beneficiary used 100 home health visits in a year, the additional costs the patient would incur due to these copayments would equal $572.[57] At present, only a small percentage of beneficiaries use 100 visits in a year. In 1982, 15 percent of the users of home health care used 50 or more visits.[58]

Another proposal would raise the SMI deductible from $75 to $100 in 1987. Beginning in 1988, the amount of the deductible would be indexed to the increase in the Medicare economic index. This is expected to reduce Medicare outlays by $310 million in fiscal year 1987 and $2,995 million over the period fiscal years 1987-91. The effect of this proposal would be to transfer some of the costs of Medicare-covered services to beneficiaries.[59]

Major Proposals to Redesign Medicare

Medicare's financing problems and the difficulty high out-of-pocket health costs cause the elderly, particularly those with low incomes, have resulted in numerous proposals for solving current problems with the acute care health system. There is, however, no consensus as to how to

[56]O'Sullivan, Jennifer, Medicare: FY 1987 Budget (Washington, D.C.: Congressional Research Service, Feb. 21, 1986), p. 11.

[57]O'Sullivan, Medicare: FY 1987 Budget, pp. 18-19.

[58]O'Sullivan, Jennifer, Medicare: FY 1986 Budget (Washington, D.C.: Congressional Research Service, Jan. 24, 1986), p. 19.

[59]O'Sullivan, Medicare: FY 1987 Budget.

reform the system; some of the proposals, which are wide-ranging in both scope and cost, are described below.

Providing Protection Against Catastrophic Health Costs

Many proposals to redesign Medicare focus on adding protection for catastrophic illness. The objective is to insure that, after individuals have spent a certain proportion of their income on health care, they would be protected from further expenditures. The Secretary of Health and Human Services has set up a task force to study the feasibility of providing protection to the elderly against catastrophic health costs with emphasis on private sector coverage.

The secretary also coauthored a proposal for restructuring the Medicare benefit package to provide catastrophic acute inpatient and outpatient care to Medicare beneficiaries in a cost-neutral manner. Under this proposal, actuarially sound premiums would be added to SMI (at an estimated cost of $12 per month extra in 1985). For this additional payment, beneficiaries would obtain coverage for unlimited acute inpatient days, would not be at risk for coinsurance, and would pay a maximum of two deductibles per year under HI.[60]

Taxing a Portion of HI and SMI Benefits

Another set of proposals would raise Medicare revenues without adding to the cost sharing of the poor elderly. Under this approach, 50 percent of the insurance value of HI benefits and 75 percent of the insurance value of SMI benefits would be treated as taxable income for enrollees with the resulting tax proceeds returned to the Medicare trust fund. This proposal is viewed as similar to taxing a portion of Social Security benefits, which is already done under law for beneficiaries "for whom modified adjusted gross income plus half of Social Security benefits exceed $25,000 (for individuals) or $32,000 (for couples)." One difference, though, is that the Medicare tax would be on the insurance value of in-kind benefits rather than on dollar benefits actually received.[61]

A recent study estimated that for SMI this change would add approximately $576 to the taxable income of each SMI enrollee in 1986. This was estimated to pose little or no cost for households with low incomes and low marginal tax rates. For elderly households with incomes greater

[60]Bowen, Otis R., and Thomas Burke, "Cost Neutral Catastrophic Care Proposed for Medicare Patients," FAH Review, Nov.-Dec., 1985.

[61]CBO, Reducing the Deficit: Spending and Revenue Options (Washington, D.C.: Mar. 1986), pp. 97-98.

than 200 percent of the poverty level in 1986, however, the tax cost of this change was estimated at $112 per household.[62]

Merging HI and SMI and Expanding Benefits

Researchers at Harvard University recently issued a report that recommends sweeping changes in Medicare, which they contend would make it less costly, simpler, and more equitable. Some of their more than 40 proposals include:

- Medicare's HI and SMI should be combined into a single mandatory program with fairer and simpler cost-sharing requirements.
- The elderly should continue to pay their present share of program costs but cost sharing through coinsurance and deductibles should be reduced.
- Beneficiaries should pay a hospital deductible equivalent to one-half of the cost of a day in the hospital and 10-percent physician coinsurance.
- The remaining costs that beneficiaries pay should be financed with a single annual Medicare premium and income tax revenues collected from taxpayers over age 65.
- To ensure that the premium does not exceed low-income beneficiaries' financial resources, all states should be required to provide Medicaid coverage and pay Medicare premiums for elderly with incomes at or below 125 percent of the poverty level.
- To prevent the accumulation of large debts during serious illness, there should be a reasonable limit on the total annual amount all beneficiaries pay for coinsurance and deductibles.
- Medicare coverage should be expanded to include better primary care services and more adequate treatment of chronic illness (including nursing home and home health care benefits).[63]

The report also recommended that the federal government control the growth of Medicare expenditures through annual budget targets for both physician and hospital expenditures and encouraged moving in the direction of an all-payer system for hospitals to prevent cost-shifting to private payers. All-payer systems involve setting limits on hospital revenues from all sources, including Medicare.[64]

[62]ICF, Inc., The Role of Medicare in Financing the Health Care of Older Americans (Washington, D.C.: July 1985), p. ii.

[63]Center for Health Policy and Management, John F. Kennedy School of Government, Harvard University, Medicare Coming of Age: A Proposal for Reform (Cambridge, Mass.: Mar. 1986), pp. vii-viii.

[64]Center for Health Policy and Management, p. viii.

Medical Individual Retirement Accounts

There also have been proposals to address the issue of financing health care for the elderly, not through further changes to Medicare, but through a private health savings program similar to an Individual Retirement Account (IRA). This approach would allow individuals to defer paying taxes on contributions and on interest earned on their accounts. Because medical IRAs would be less liquid than regular IRAs, however, it is postulated that the tax advantage would have to be relatively great to foster their widespread use.[65]

Whether this approach would work depends on whether the population would save specifically for postretirement health costs in response to federal tax incentives. Participation in current IRAs is not widespread; only 17 percent of workers had IRAs in 1982.[66] In addition, preliminary results from an Employee Benefit Research Institute forecast indicate that few workers will have accumulated IRA assets that yield more than $1,500 in annuity income (in 1985 dollars) in retirement. Given the low rate of IRA savings, it is thought unlikely that a medical IRA could replace a major portion of Medicare spending, especially for low- and middle-income workers.[67]

A Voucher Program

In the administration's fiscal year 1987 budget, a voucher program under which beneficiaries could elect to receive services through a private health benefits plan rather than under Medicare is proposed. Participation would be voluntary, and beneficiaries could elect to return to the regular Medicare program.

Advocates of the voucher system contend it would foster greater competition in the provision of health services to beneficiaries and moderate general increases in health care spending and out-of-pocket costs for the elderly. Critics question whether the voucher plan would have any effect on costs or utilization, as they foresee the higher risk aged and disabled population remaining in the Medicare program. They also question how quality and access would be assured under a voucher program

[65]Employee Benefit Research Institute, "Congress Explores Medical IRAs," Notes, Jan. 1986, Vol. 7, No. 1, p. 11.

[66]Employee Benefit Research Institute.

[67]Employee Benefit Research Institute.

and suggest that the Medicare program actually can offer health insurance at a lower cost than private plans because the program does not need to spend money on marketing.[68]

The administration's budget projects that the proposed voucher program could increase outlays by $50 million in fiscal year 1987 and $250 million over the period fiscal years 1987-91.[69]

[68]Davis, Karen, and Diane Rowland, Medicare Policy: New Directions for Health and Long-Term Care (The John Hopkins University Press: Baltimore Md., 1986), p. 78.

[69]O'Sullivan, Jennifer, Medicare: FY 1987 Budget, p. 11.

Long-Term Care a Growing Problem, Especially for Elderly and Their Families

While out-of-pocket costs for acute care can be problematic for the population age 65 and older, for some elderly the cost of long-term care produces financial catastrophe. A portion of this care is paid for out of public funds (mainly through the Medicaid program), but the major responsibility falls to the elderly themselves. Consequently, the elderly and their families often face large financial burdens in paying for long-term care; in some cases this leads to financial destitution.

Current problems in paying for long-term care may become pronounced over the next several decades. The population age 85 and older, which comprises those individuals most in need of long-term care, will be increasing at a faster rate than the total number of elderly. In addition, the availability of informal long-term care from family members, who historically have provided most such services, may decline during the same period. If this occurs, out-of-pocket costs for long-term care are likely to increase further.

Need for Long-Term Care to Increase

Long-term care has been defined as:

"... one or more services provided on a sustained basis to enable individuals whose functional capacities are chronically impaired to be maintained at their maximum levels of psychological, physical and social well-being. The recipients of services can reside anywhere along a continuum from their own homes to any type of institutional facility."[1]

Over the past 2 decades, there has been a growing focus on the elderly's needs for long-term care services. This is a consequence of the dramatic change in life expectancy since the turn of the century and subsequent increases in diseases and chronic illnesses associated with aging and longevity. As a result, the elderly increasingly have health care needs that require long-term care services, including help with ordinary daily activities.[2]

Health of Elderly Population Diverse

Most elderly are in good health and able to live independently. A significant number, however, are in need of long-term care services. Findings from the 1982 National Long-Term Care Survey showed that in 1985

[1]E. M. Brody, "The Formal Support Network: Congregate Treatment Setting for Patients With Senescent Brain Dysfunction" (Bethesda, Md.: Dec. 1978), p. 1.

[2]Day, Alice T., Who Cares? Demographic Trends Challenge Family Care for the Elderly (Washington, D.C.: Population Reference Bureau, Inc., Sept. 1985, No. 9), pp. 6-7. See also Beth T. Soldo and Kenneth Manton, "Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends," Milbank Memorial Fund Quarterly/Health and Society, Vol. 63, No. 2, 1985, pp. 286-319.

approximately 4.6 million, or 18.9 percent, of individuals age 65 and older living in the community were in need of some help with the activities of daily living (ADL) or instrumental activities of daily living (IADL).[3] As shown in table 4.1, 3.5 percent of the total elderly population living in the community had severe limitations.[4]

Table 4.1: Distribution of the Population 65 and Over in the Community With Limitations on Activities of Daily Living, by Age and Sex

	Percent of population 65 and over with	
Age/sex	ADL/IADL limitations	Severe (high ADL) limitations
65-74	12.6	2.1
Male	11.7	2.4
Female	13.3	1.9
75-84	25.0	4.5
Male	20.9	4.6
Female	27.6	4.4
85 and over	45.8	10.4
Male	40.8	7.5
Female	48.2	11.8
Total all 65 and over	18.9	3.5
Male	16.0	3.3
Female	20.9	3.6

Source: Kenneth G. Manton and Korbin Liu, "The Future Growth of the Long-Term Care Population: Projections Based on the 1977 National Nursing Home Survey and the 1982 Long-Term Care Survey," Mar. 1984.

The need for assistance increases with age. Approximately 12.6 percent of persons age 65-74 were identified in the 1982 survey as needing assistance with personal care activities due to chronic illness. In contrast, 45.8 percent of individuals 85 or older needed assistance.[5]

[3]ADL indicators were bathing, dressing, eating, getting out of bed, getting around indoors, and toileting. The IADL indicators were managing money, moving about outdoors, shopping, doing heavy housework, meal preparation, making phone calls, and taking medication. Korbin Liu, Kenneth G. Manton, and Barbara Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Vol. 7, No. 2, Winter 1985, p. 52.

[4]Manton, Kenneth G., and Korbin Liu, "The Future Growth of the Long-Term Care Population: Projections Based on the 1977 National Nursing Home Survey and the 1982 Long-Term Care Survey," prepared for presentation at the Third National Leadership Conference on Long-Term Care Issues, Washington, D.C., Mar. 7-9, 1984, p. 7 and table 3. Individuals with severe limitations had an ADL score of five or six limitations; these individuals had greater physical resource requirements than individuals with lower scores.

[5]Manton and Liu.

The leading health problems limiting activity by the elderly in 1982 were arthritis, hypertensive disease, hearing impairments, and heart conditions. Older men were more likely to experience acute illnesses that were life-threatening, such as coronary heart disease, while older women were more likely to have musculoskeletal diseases, such as osteoporosis, that caused physical limitations.[6] Dementia is another problem requiring long-term care. This is considered to be the primary mental health problem of the elderly and a major reason for institutionalization in a nursing home.[7] It can be caused by more than 60 disorders, but a leading cause is Alzheimer's disease, a progressive and irreversible neurological disorder estimated to affect 2.5 million American adults.[8] The prevalence of "severe" dementia (where the patient is so incapacitated that institutional or full-time care in a home is needed) is less than 1 percent of persons age 65 or older but more than 15 percent of those age 85 or older. Among those older than 65, the incidence of dementia is predicted to become greater as the average age of the population over 65 increases.[9]

Growth in Elderly Population to Increase Long-Term Care Needs

Several trends in the aging population will contribute to the increased need for long-term care. The number of elderly with disabilities, for example, is projected to increase 45 percent from 1980 to 1995; the size of the most severely disabled group is projected to increase by 49 percent during this time.[10]

Also, the number of individuals at risk of needing nursing home care will be increasing over the next several decades. These are predominantly women living alone, who have the highest number of disabilities, need financial assistance and help with activities of daily living, and are generally in the oldest age groups. In 1985, an estimated 16 percent of the elderly age 85 or older was in a nursing home compared with 2 percent of those between 65 and 74.[11]

[6]U.S. Senate, Special Committee on Aging, Aging America: Trends and Projections, 1985, 1986 ed. (Washington, D.C.: GPO, 1986), pp. 88-89.

[7]Katzman, Robert, "Medical Progress: Alzheimer's Disease," The New England Journal of Medicine, Vol. 314, No. 15, Apr. 10, 1965, pp. 965-966.

[8]Alzheimer's Disease and Related Disorders Association, Inc., "Fact Sheet on Alzheimer's Disease" (Chicago, Ill.), p. 1.

[9]Katzman, p. 966.

[10]Manton and Liu, p. 8.

[11]Manton and Liu, p. 10 and table 8.

Role of Informal Caregivers May Change

At the same time the aging of the population causes the need for long-term care to expand, other changes are likely to increase the demand for formal care provided outside of the family. Currently, disabled elderly who live outside of a nursing home receive 80 percent of their care informally from relatives; placement in a nursing home is usually a last resort. A large proportion of the elderly in nursing homes, for example, are there because they have no close relatives or suffer from disabilities (e.g., Alzheimer's disease) that are difficult to care for at home.[12]

In the future, limitations on the family's ability to provide care may increase the need for formal sources of care (such as paid providers of home health, homemaker/chore, and adult day care services).[13] In 1982, formal sources of care accounted for less than 15 percent of all helper days in the community.[14] This could grow, however, due to:

- Increases in life expectancy, delayed marriage, and an increased ratio of elderly parents to children to look after them (a result of fewer children per family on average).
- Differences in mortality by sex at all ages, which mean that older women are more likely to be widowed than older men. As a result, women are at greater risk of institutionalization as they lack a spouse to care for them at home if they become ill.[15]
- As the population ages, the greater likelihood that very old chronically ill parents will have children who are themselves retired and may be less able to provide help.

[12]Day, pp. 1, 4-5.

[13]The future elderly are projected to be better off financially than their predecessors and, therefore, may be more likely to be able to pay for this care. At the same time, however, future income improvements are likely to be uneven, and many elderly still will enter retirement with limited savings and low Social Security benefits. Also, for many elderly, resources available at retirement could be depleted by the time they need formal long-term care (often 15 to 20 years later). William Scanlon and Judith Feder, "The Long-Term Care Marketplace: An Overview," Healthcare Financial Management, Vol. 14, No. 1, Jan. 1984, p. 36.

[14]U.S. Senate, Special Committee on Aging, Developments in Aging: 1985, Vol. 1 (Washington, D.C.: GPO, 1986), p. 245.

[15]Preliminary data from the Health Interview Survey found that about one-third of all individuals 65 and older outside of nursing homes or institutions were living alone and were predominantly older widowed women. Twenty-nine percent were estimated to have no living children and an additional 19 percent had only one child. M. G. Kovar, "Aging in the Eighties, Age 65 Years and Over and Living Alone, Contacts with Family, Friends, and Neighbors." Preliminary data from the National Health Interview Survey: U.S., January-June 1984, HHS, National Center for Health Statistics, Advance Data, No. 116, May 9, 1986, p. 2.

- Increased participation of women in the labor force, which may decrease the amount of time spent by them in providing informal care.[16]

Currently, most elderly who need help with long-term care services are very old and are widowed. The individuals who predominantly provide this assistance are their daughters and to a lesser extent daughters-in-law. Among the still-married elderly, spouses (mainly wives) provide most of the care.[17] Many of these caregivers themselves are old; according to a 1982 national survey, the average age of all those providing care was 57 and a third were 65 or over. Hence, predominantly the young old were found to be caring for the older elderly, because over half of those receiving care were 75 and older.[18]

The burden of caregiving can be heavy, particularly in the cases of patients suffering from disorders that cause deteriorating mental function (dementia). Most of these patients need 24-hour supervision and medical and personal care. Little help is available because Medicare does not cover custodial care, and there is little additional public or private insurance to cover the services that would provide support to the caregiver, such as adult day care, personal care, or respite services. This creates a problem for caregivers who themselves may have low incomes or be in poor health. In the 1982 National Long-Term Care Survey, a third of the caregivers described their own health status as fair to poor.[19]

Public, Private Spending for Long-Term Care Rising

Given the factors discussed above, the growth in the elderly population is projected to significantly increase the need for long-term care. This could occur at the same time the elderly are already facing high and often catastrophic costs in paying for such services. In addition, the costs to the elderly for long-term care as well as public expenditures for it are expected to continue to increase.

[16]Day, pp. 6, 8, 10.

[17]Day, p. 8.

[18]Stone, Robyn, Gail Lee Cafferata, and Judith Sangl, Caregivers of the Frail Elderly: A National Profile (Washington, D.C.: HHS, 1986), pp. 4, 18.

[19]Stone, Cafferata, and Sangl, p. 5.

Current National Expenditures

National aggregated data on expenditures for long-term care are not readily available. One reason is that, while Medicaid is the primary funding source, approximately 80 federal programs assist persons with long-term care needs either through cash assistance, in-kind transfers, or provision of services or supplies. There is agreement, however, that most national expenditures for long-term care are for nursing home or other institutional services.[20] While in 1985, $35.2 billion was spent on nursing home care,[21] this is projected to grow to $55 billion in 1990. The projection is based on the demographic shifts toward an elderly population, specifically at the oldest ages.[22]

Medicaid: Major Public Payer for Long-Term Care

Almost half of the expenditures for long-term care is publicly funded, the largest portion by Medicaid. In 1985, federal, state, and local Medicaid expenditures for nursing home care totaled $14.7 billion. Medicare paid for only a small proportion, $600 million, of nursing home expenditures nationally in 1985.[23]

In contrast, public expenditures for home health care and other community-based long-term care services are small. Medicaid spending on home health care represented 1.8 percent of total expenditures ($600 million) in 1983, with New York accounting for nearly 80 percent of this total. Medicare spending for home health benefits, $1.5 billion, represented 2.7 percent of total program expenditures in 1983.[24] Expenditures for this service have been increasing, however, and have doubled from $735 million in 1980 to $1.5 billion in 1983.[25]

Many other federal sources also provide lesser amounts of financing for long-term care for the elderly. These include: the Social Services Block Grant (particularly for homemaker/chore services); the Older Americans Act, which provides home-delivered meals, congregate meals, and some in-home support services; and the Veterans Administration, which

[20]O'Shaughnessy, Carol, Richard Price, and Jeanne Griffith, Financing and Delivery of Long-Term Care Services for the Elderly, Congressional Research Service, Oct. 17, 1985, p. 14.

[21]HHS, HCFA, July 29, 1986. Information to be published in Health Care Financing Review, Fall 1986.

[22]Arnett, Ross H., III, et al., "Health Spending Trends in the 1980's; Adjusting to Financial Incentives," Health Care Financing Review, Spring 1985, Vol. 6, No. 3, pp. 22-23.

[23]HHS.

[24]O'Shaughnessy, Price, and Griffith, p. 15.

[25]Doty, Pamela, Korbin Liu, and Joshua Wiener, "An Overview of Long-Term Care," Health Care Financing Review, Vol. 6, No. 3, Spring 1985, p. 73.

covers nursing home care, domiciliary care, outpatient clinics, and adult day care services as well as providing cash payments for aid and attendance for certain veterans. The SSI program and most states' SSI supplements provide payments to persons residing in domiciliary care facilities (which provide nonmedical residential long-term care).[26]

Catastrophic Expenses Faced by Elderly, Their Families

While a portion of long-term care is paid for out of public funds, the major responsibility for the cost of care falls upon the elderly themselves. Public programs (specifically Medicaid) typically only pay for care when the elderly or their families cannot.

Based on the 1982 Long-Term Care Survey, an estimated 1.1 million elderly spent $1 billion out of pocket for long-term care services provided in their own homes.[27] In 1984, 50 percent of payments for nursing home care came from individuals; only 1.1 percent was paid by private insurance plans.[28] Historically, the private insurance industry has provided limited long-term care coverage, most covering only Medicare copayments.[29]

These large out-of-pocket costs find most elderly and their families unprepared because many are unaware of their lack of protection against long-term care costs. A survey commissioned in 1983 by the American Association of Retired Persons of its members found the majority believed that Medicare would be the primary payer for long-term care with private insurance and savings as secondary sources.[30]

Because of the limited coverage under Medicare and private insurance policies, Medicaid has become the predominant public payer of long-term care. Under Medicaid, states (except Arizona) must provide coverage for (1) care in skilled nursing facilities (SNFs) and home health services to persons 21 years of age and older and (2) home health services to persons under 21 if the state provides SNF services to that age group.

[26]O'Shaughnessy, Price, and Griffith, pp. 16-33.

[27]Liu, Manton, and Liu, p. 54.

[28]Employee Benefit Research Institute, "Financing Long-Term Care," Issue Brief, No. 48, Nov. 1985, p. 5.

[29]GAO, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly (GAO/IPE-84-1), Oct. 21, 1983, p. 4.

[30]Brickfield, Cyril F., "Long-Term Care Financing Solutions Are Needed Now," AHCA Journal, Vol. 11, No. 6, Oct. 1985, p. 14.

They also have the option of providing care in intermediate care facilities (ICFs). Forty-nine states and the District of Columbia cover this less intensive form of nursing home care.[31] In 1982, recipients of nursing home care were 7.3 percent of the total Medicaid population, yet nursing home costs equaled 43 percent of all Medicaid expenditures in that year.[32]

Only Destitute Individuals Covered by Medicaid

Medicaid assists individuals in paying for nursing home care only if they have low incomes or if they become impoverished while in a nursing home. At a cost of $2,100 or more a month, the expense of receiving care in a nursing home can wipe out an elderly person's savings and far exceed monthly income.[33] For some elderly persons, to enter a nursing home means depending on Medicaid because the cost of care exceeds their personal resources. In other cases, an elderly person who initially has economic resources above Medicaid eligibility limits and enters a nursing home as a private-paying resident finds that the cumulative cost of the stay depletes his or her personal resources. That individual may then also become eligible for Medicaid.[34]

After a person becomes Medicaid-eligible, he or she must contribute all personal resources (except for $25 per month) toward the cost of care. This creates a problem for many persons; if the spouse depends on shared income and savings and remains at home, the amount set aside for the spouse to live on may be substantially below the poverty level.[35]

[31]Doty, Liu, and Wiener, pp. 73-74.

[32]HHS, HCFA, Office of Research and Demonstrations, Studies Evaluating Medicaid Home and Community-Based Care Waivers (Washington, D.C.: Dec. 1984), p. 19.

[33]Employee Benefit Research Institute, p. 8.

[34]GAO, p. 5.

[35]Feder, Judith, and William Scanlon, "Financing Effective Long-Term Care for the Elderly" (Washington, D.C.: Center for Health Policy Studies, Georgetown University, 1984), p. 6.

States Act to Reduce Medicaid Spending on Long-Term Care

Even in the face of an increasing public need for assistance, states have been taking steps to reduce their long-term care expenditures. Typically, Medicaid spending is the most rapidly rising component of a state's budget and nursing home care often the largest Medicaid expense. In 1982, for example, 27 states spent 50 percent or more of their Medicaid budgets on nursing home care.[36]

Facing fiscal constraints, many states have attempted to contain Medicaid costs, especially for care in nursing homes. Such efforts include regulating the nursing home bed supply, restricting reimbursement, or both to slow the growth in their Medicaid programs. Some states are also attempting, through policies and legislation, to require relatives to reimburse the state for patients' Medicaid assistance.[37]

State efforts to contain the number of nursing home beds could, however, add to problems Medicaid patients already experience in obtaining care. Generally, high occupancy rates mean that private-pay patients who pay full nursing home charges are likely to receive preference whatever their degree of need; Medicaid patients fill whatever beds remain. Even when beds are available, because most states reimburse for nursing home care at rates not directly related to individuals' care needs, Medicaid patients requiring fewer services—and thus representing lower costs—are preferred over "heavy care" patients.[38]

Thus, a tight nursing home bed supply may prevent some patients with heavy care needs from receiving care. A study based on 1977 data (the latest available nationally on nursing home utilization) found that in states with a low bed supply (fewer than 44 beds per 1,000 residents age 65 and older) approximately half of the highly dependent elderly population was in nursing homes. In states with the highest supply of beds (more than 85 beds per 1,000 residents age 65 and older), almost all individuals in the highly dependent group (92.1 percent) were in nursing homes.[39]

[36]HHS, HCFA, Office of Research and Demonstrations, Health Care Financing Grants and Contracts Report, Short-Term Evaluation of Medicaid: Selected Issues (Baltimore, Md.: 1984), p. 146.

[37]GAO, p. 8.

[38]GAO, p. 17.

[39]Weissert, William, and Bill Scanlon, Determinants of Institutionalization of the Aged (Washington, D.C.: The Urban Institute, Nov. 1982), p. 15. (With respect to utilization data, the National Center for Health Statistics has launched the 1985 National Nursing Home Survey—the first since 1977—which will involve 1,200 of the nation's 18,000 nursing homes.)

In the highest-bed states, there was apparently a nursing home bed supply sufficient to permit almost all highly dependent elderly people to enter nursing homes. In lowest-bed states, such was not the case. This may indicate both some overuse of institutional care in the highest-bed states (if some of these individuals could have been cared for in other settings) and an inadequate supply of services for the highly dependent in the lowest-bed states.

Many states, to moderate the rate of increase in Medicaid expenditures for long-term care, have tightened their reimbursement systems for nursing home care. This may have added to the access problem some Medicaid patients experience. Some states, however, have been experimenting with case-mix reimbursement systems, designed to recognize different levels of complexity in patient care needs, to eliminate disincentives to admission of heavy-care patients.[40]

Other states have adopted legislation or policies that address the problem of a tight bed supply and constrained reimbursement rates causing nursing homes to choose private-pay over Medicaid patients. The California legislature recently outlawed discrimination against patients on the basis of source of payment. It prohibited nursing homes from transferring or evicting any resident as a result of the resident's changing from Medicare or private insurance to Medi-Cal (California's Medicaid program) as the source of payment.[41]

Quality of Nursing Home Care Causes Concern

In addition to financing problems in long-term care, there is concern over the quality of care Medicare and Medicaid patients receive in nursing homes. A recent study by the Institute of Medicine of the National Academy of Sciences concluded that, while the quality of care and life in many nursing homes nationally had generally improved over the last decade, it still was not satisfactory and a stronger federal regulatory role was needed to protect patients' rights and improve care.[42] Also, state supervision was lax, the institute reported, and the federal

[40]Meiners, Mark R., et al., Nursing Home Admissions: The Results of an Incentive Reimbursement Experiment (Washington, D.C.: HHS, National Center for Health Services Research and Health Care Technology Assessment, Oct. 1985), p. 5. See also Charlene Harrington and James H. Swan, "Medicaid Nursing Home Reimbursement Policies, Rates and Expenditures," Health Care Financing Review, Vol. 6, No. 1, Fall 1984, pp. 39-47.

[41]Merritt, Dick (ed.), "Long-Term Care Reforms Targeted," State Health Notes, No. 53, May 1985, p. 1-2.

[42]Institute of Medicine, Improving the Quality of Care in Nursing Homes," (Washington, D.C.: National Academy Press, 1986), p. 21.

government rarely used its authority to check on patients. Finally, the institute concluded, because of the short supply of nursing home beds, the federal government seldom applied the sanction of refusing to allow Medicare or Medicaid reimbursement.[43]

Concerns that some current cost containment efforts in Medicaid nursing home reimbursement could have a negative impact on quality of care were raised in a recent study of 3 years of cost data in eight states.[44] A new government system of surveying nursing homes, effective July 1986, may begin to address some of these issues regarding the quality of care. Administered by HCFA, the Patient Care and Services Survey will emphasize patient observations and interviews rather than paperwork evaluations.

Medicare's Prospective Payment System Adding to Demand for Community-Based Care

Medicare's new prospective payment system, with its emphasis on earlier hospital discharges, is placing increased demand on home care, nursing home, and other support services that provide care for the homebound. For example, in fiscal year 1984 the percentage of times hospitals discharged Medicare patients to skilled nursing homes, intermediate care facilities, and home health agencies was 2.5 to 3 times as high for PPS hospitals as for non-PPS hospitals.[45]

As a result of PPS, nursing homes are sometimes asked to accept patients needing more intensive and extensive care than previously; also, home health services may need to be expanded to provide more frequent home visits, not only by nurses but by nursing assistants and home health aides. Further, many patients will face bills for services in a nursing home or from a home health agency that previously would have been paid when Medicare covered the full hospital stay.[46]

The advent of PPS highlights the need for consistency between the objectives of the new payment system (i.e., to treat patients when feasible on an outpatient basis) and cost containment initiatives for home health

[43]Institute of Medicine, p. 13.

[44]Holahan, John, How Should Medicaid Programs Pay for Nursing Home Care? (Washington, D.C.: The Urban Institute, Jan. 1985), p. v.

[45]HHS, HCFA, Office of Research and Demonstrations, Impact of the Medicare Hospital Prospective Payment System, Aug. 1986, p. xvi.

[46]Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System, (Washington, D.C.: Feb. 1986), p. 5.

care services under Medicare. Currently, while utilization and costs in skilled nursing facilities and home health care agencies are increasing due to discharges from shorter hospital stays, ongoing changes within the Medicare home health care program are directed toward better enforcement of the program's regulations limiting utilization and controlling the rate of increase in unit costs.[47]

How to Best Provide Long-Term Care? Consensus Lacking

PPS's potential for increasing the demand for long-term care has added to the impetus to seek improvements in the long-term care system. A major stumbling block to reform, however, has been the lack of agreement about how to revise the system and recognition that enormous costs could result if access to care is improved.[48]

In an effort to reduce nursing home costs and provide long-term care services to individuals who prefer to remain in their own homes, states have been experimenting with ways to expand community-based long-term care. The Medicaid Home and Community-Based Services Program, enacted in the Omnibus Budget Reconciliation Act of 1981 (section 2176), was intended to remove some of Medicaid's emphasis on providing institutional placements by allowing states waivers to test alternative forms of long-term care. Under such waivers, states can provide noninstitutional long-term care services (e.g., case management, homemaker, home health aide, adult day care and respite care) to persons who would otherwise require Medicaid-financed nursing home care.[49]

As of May 1985, HCFA had approved 102 waiver requests submitted by 46 states.[50] In spite of this large number of waivers, the program is still relatively small because states have experienced implementation problems, and many have restricted the number of services provided or the number of individuals who could participate under their section 2176 waivers. HCFA requires a state to demonstrate that its waiver program

[47]Van Gelder, Susan, and Jill Bernstein, "Home Health Care in the Era of Hospital Prospective Payment: Some Elderly Evidence and Thoughts About the Future," Pride Institute Journal of Long-Term Health Care, Vol. 5, No. 1, Winter 1986, pp. 9, 10.

[48]Somers, Anne R., "Financing Long-Term Care for the Elderly: Institutions, Incentives' Issues," America's Aging/Health In An Older Society, National Academy Press (Washington, D.C.: 1985), pp. 215-229.

[49]O'Shaughnessy, Carol, and Richard Price, Medicaid "2176" Waivers For Home and Community-Based Care (Washington, D.C.: Congressional Research Service, June 21, 1985), p. 1-4.

[50]O'Shaughnessy and Price, p. 47.

would not increase the total number of Medicaid long-term care recipients and would be budget-neutral.[51] Thus, to offset the increased expenditures for community-based services under the waiver program, states would need to reduce the number of nursing home bed days for which Medicaid pays.[52]

Earlier demonstrations did not, however, conclude that expanding community-based services reduced nursing home costs. A major reason is that many individuals, regardless of disability, would never enter a nursing home, but would use and potentially benefit from home health care services if these were available and covered under public or private insurance. As a result, expanding the financing of home and community-based care under the section 2176 program could accelerate Medicaid expenditures with little effect on containing nursing home costs.[53]

More recently, HHS funded a demonstration to test the cost-effectiveness of home care over care in a hospital or nursing home. Initiated in 1980, the National Long-Term Care Channeling Project served elderly clients at 10 sites across the country. A main objective was to test whether, through monitoring and provision of long-term care services, the cost of care could be reduced at the same time the patient's health was maintained. Channeling was expected to achieve its objectives primarily by substituting less costly community or informal services for more costly institutional care.[54]

The projects were successful in targeting services to an extremely frail elderly population who had low incomes and reported many unmet health care needs, according to major findings reported in July 1986. Also, the channeling demonstration substantially increased clients' receipt of formal community services, reduced their reported unmet needs for services, and had some beneficial effects on their psychological and social well-being. But neither hospital nor nursing home use was affected, and the projects also resulted in an increase in the total

[51]HHS, HCFA, Office of Research and Demonstrations, Studies Evaluating Medicaid Home and Community-Based Care Waivers, pp. 32, 50-53, 100-102.

[52]Curtiss, Richard E., and Lawrence R. Bartlett, "High Cost of Long Term Care Squeezes State Budgets," Generations, Vol. IX, No. 1, Fall 1984, p. 23.

[53]GAO, The Elderly Should Benefit From Expanded Home Health Care But Increasing These Services Will Not Insure Cost Reductions (GAO/IPE-83-1), Dec. 7, 1982.

[54]HHS, National Long-Term Care Channeling Demonstration Program, pp. 1, 8-9.

per-client costs of subsistence and medical and long-term care over the 18-month observation period.[55]

Reforms of Long-Term Care System Proposed

Resolution of long-term financing problems faced by the elderly and their families is one of the most pressing issues affecting the financial well-being of the elderly. As previously noted, however, there is no agreement on the best approach to organizing the delivery of these services while assuring quality of care and access to it and containing public expenditures. Numerous proposals have been advanced for reforming the long-term care system. Some focus on expanding the private sector role while others would significantly broaden the federal role. The major proposals are discussed below.

Private Long-Term Care Insurance

Currently, there is considerable national interest in expanding private long-term care insurance, which is seen as a way to protect individuals from catastrophic expenses while potentially saving Medicaid costs. These insurance policies typically cover benefits in SNFs; they less often cover custodial or intermediate care and home health care.

Several factors are believed to explain the current low rate of insurance coverage for long-term care among the elderly:

- the public impression that Medicare and private insurance (i.e., Medigap policies) already cover long-term care costs,
- the existence of Medicaid as a free long-term care program,
- the fact that for the most part long-term care insurance policies have been sold to individuals, making them more expensive than if marketed to groups, and
- the risk of adverse selection (i.e., individuals most needing this care are most likely to purchase insurance) and the likelihood that individuals, once they pay for long-term care insurance coverage, are more likely to use it.[56]

Although most private long-term care insurance plans focus on coverage for nursing home care, these policies generally are less attractive to the

[55]HHS.

[56]Davis, Karen, and Diane Rowland, Medicare Policy: New Directions for Health and Long-Term Care (Baltimore, Md.: The Johns Hopkins University Press, 1986), p. 91; and James R. Knickman and Nelda McCall, "A Prepaid Managed Approach to Long-Term Care," Health Affairs, Spring 1986, pp. 91-92; and Employee Benefit Research Institute, p. 9.

elderly, who would prefer to purchase coverage for community-based long-term care services. In a 1983 survey, the American Association of Retired Persons asked its members whether they would prefer a long-term care insurance plan that covered only care in a nursing home or nursing care in their own homes as well. Six percent preferred coverage for nursing home care and 77 percent said they preferred coverage to receive care in their own homes.[57]

High premium costs also would deter participation in private long-term care insurance; they would result if the plans were modeled after standard insurance policies. As the risk of needing nursing home care increases with age, premiums are likely to increase with age. The individuals most in need of coverage, therefore, may find themselves least able to afford it. Under standard health insurance policies, failure to pay premiums for a given year would end insurance coverage regardless of for how many years the premiums had been paid. Consequently, even relatively well-off elderly could find themselves unable to maintain their protection if they lived a long time.[58]

In spite of these unresolved issues, many states are considering legislation that would mandate coverage of some long-term care services beyond the scope of existing benefits in nursing home policies or require insurers to offer such benefits in optional riders to group insurance plans.[59]

Life-Care Communities

Life-care communities are settings that combine residential living for the elderly with the availability of medical, nursing, and social services in specialized facilities on the premises.[60] Typically, financing comes from entrance fees that range from $50,000 to $80,000 and monthly fees that range from $900 to $1,300.[61]

While there has been growing interest in these communities, their high costs make them accessible to only a small proportion of the elderly.

[57]Brickfield, p. 14.

[58]Feder and Scanlon, p. 18.

[59]Intergovernmental Health Policy Project, "States Approach Long-Term Care Insurance With Caution," State Health Notes, No. 61, Mar. 1986, p. 1.

[60]Doty, Liu, and Wiener, p. 76.

[61]Employee Benefit Research Institute, pp. 9-10.

Approximately 1 to 1.3 million elderly are estimated to have sufficient assets and income to enter life-care communities.

Another problem with life-care communities concerns assuring appropriate protection for residents. Currently there are few regulations governing either the financing of these facilities or the health care provided.[62]

Home Equity Conversions

There also has been interest in home equity conversions as a way to help the elderly finance their long-term care needs. Approximately 75 percent of the elderly own their own homes with a net home equity estimated at approximately $550 billion. Most elderly homeowners, however, cannot obtain cash from their homes without selling. Given the importance of a home as shelter, this makes it difficult for the elderly to tap the resources they have tied up in their homes should they incur large health care costs.[63]

Home equity conversion, which means converting the equity in one's home to cash without having to find another residence, has been proposed as a solution to these problems. Participation in home equity conversions has been limited; nationally very few transactions have occurred. In studying these conversions, single women without heirs were found to be most likely to participate. The funds received were used to supplement income or meet short-term medical crises.

Problems with the feasibility of home equity conversions include the reluctance of the elderly to participate, regulatory and legal problems, and the fact that those who do participate might use the cash for purposes other than medical or long-term care bills.[64]

Incentives for Family Care

There have been numerous proposals to provide support to family caregivers as a way to extend the time they can provide care to their disabled relatives in the community, thereby potentially deterring or postponing a nursing home placement. One proposal would expand the public financing of respite services beyond the limited coverage currently available under Medicaid. These services would mean that family

[62]Employee Benefit Research Institute.

[63]Davis and Rowland, p. 87.

[64]Davis and Rowland, pp. 87, 89.

members could take a break or a vacation from the daily demands of providing care. Other proposals would give families tax deductions or credits to help offset some of the expenses incurred for helping disabled individuals remain in their homes.[65]

Another proposal involves the increased use of devices and techniques that could lessen the burden of caregiving and help the elderly remain independent longer. A recent study by the Office of Technology Assessment noted that technologies to assist patients and caregivers are used more extensively in Europe than in the United States. Currently, coverage for these devices is limited; there is also limited availability of skilled health care personnel trained to use these technologies and teach the patient and family how to use them.[66]

Social Health Maintenance Organizations

The concept of social health maintenance organizations involves providing and financing a full range of long-term care and medical services to an elderly population eligible for Medicare and/or Medicaid under a fixed budget that is prospectively determined. Currently, HCFA is testing the concept as part of a 3-year demonstration (which began in 1985) at four sites around the country. The objective is to provide information about

- the cost effectiveness of providing services in an integrated and managed system of care,
- the effect on utilization of health and long-term care services by the elderly, and
- the effect on the quality of care available to the eligible population.[67]

Because of the risk of catastrophic costs involved in providing long-term care benefits (especially nursing home care), however, even in these demonstration projects the depth of coverage for long-term care benefits is limited.[68]

[65]GAO, Assessment of the Use of Tax Credits for Families Who Provide Health Care to Disabled Elderly Relatives (GAO/IPE-82-7), Aug. 27, 1982.

[66]Office of Technology Assessment, Technology and Aging in America (Summary) (Washington, D.C.: Oct. 1984), p. 31.

[67]O'Shaughnessy, Price, and Griffith, pp. 36-37.

[68]Knickman and McCall, p. 98.

Long-Term Care Block Grant

There have been several proposals to change significantly the way Medicaid covers long-term care. The administration's New Federalism initiative in the early 1980's included a proposal to federalize Medicaid; this would have ended entitlement to long-term care under this program. Instead, such services would have been covered under a new block grant.

Recently the Committee on Federalism and a National Purpose recommended that the federal government assume policy and financial responsibility for Medicaid (at 90-percent federal funding) with uniform minimum standards for eligibility and a minimum set of services. As part of this plan, they also proposed to separate the nonmedical component of long-term care from the rest of Medicaid. These long-term care services would be financed subsequently by block grants to the states that would be indexed for changes in the program's cost and the population served.[69]

Block grant proposals have been supported by those who believe the states would be better than the federal government at reforming long-term care. On the other hand, this approach could increase states' financial problems if they underestimate the financial burden of providing long-term care to an increasingly aged population. Also, some of the poorer states may not be able to keep up with the number of individuals in need of these services; this would add to the elderly's problems.[70]

Restructuring and Expanding Medicare

Medicare coverage needs to be expanded to provide more adequate treatment of chronic illness despite the substantial public cost involved, a recent study by the Harvard Medicare Project concluded as part of a series of recommendations. The study proposed that Medicare

- pay for home health care and outpatient mental health care for the chronically ill,
- provide comprehensive coverage of nursing home care,
- cover the costs of care coordination and gatekeeping (gatekeepers would determine eligibility for services to prevent unnecessary use of long-term care benefits), and

[69]Committee on Federalism and a National Purpose (Daniel J. Evans and Charles Robb, chairmen), To Form a More Perfect Union (Washington, D.C.: National Conference on Social Welfare, Dec. 1985), pp. x-xi, 4.

[70]Davis and Rowland, p. 101, and GAO, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly (GAO/IPE-84-1), Oct. 21, 1983, p. iv.

- finance long-term care in the same general way as other Medicare costs but phase in this financing burden over a 10-year period. (A copayment would be required for nursing home care.)[71]

An alternative proposal would improve Medicare's coverage of long-term care as well as acute care services. This proposal would merge the HI and SMI parts of Medicare into a single plan, develop a new voluntary long-term care plan as part of the program, and design a separate Medicaid program for Medicare beneficiaries that would provide wrap-around protection for low-income elderly. These benefit improvements would be financed by an income-related premium; however, a ceiling would be placed on the out-of-pocket costs beneficiaries would incur. Federal general revenues would be used to cover any long-term care expenditures not covered by the premium.[72]

Also, this proposal would allow beneficiaries to enroll in the long-term care plan as early as age 60 (with benefits beginning after an individual had been enrolled 5 years) and would institute a direct grant program to public and nonprofit community organizations to provide home help services (such as chore services and personal care services to the chronically ill).[73]

An Incremental Approach to Long-Term Care Change

Given the costs and organizational difficulties involved in any major proposal to reform long-term care, a more incremental approach has been proposed by health care researchers to address the more urgent short-term problems and gain more information for devising long-range comprehensive reforms. This approach would involve:

- Expanding Medicare's short-term nursing home benefits. This would add coverage for recuperating patients in need of supportive care (not skilled care), which would protect beneficiaries from the financial catastrophe of recuperation from acute illness.
- Expanding tax credits to families caring for impaired relatives to help them purchase substitute, alternative, or respite care. This would help to alleviate some of the family's burden in providing care to their functionally impaired relatives.

[71]Harvard University, Division of Health Policy Research, Medicare Coming of Age: A Proposal for Reform (Cambridge, Mass.: Harvard University, Mar. 1986), pp. vii, 13.

[72]Davis and Rowland, pp. 110-112.

[73]Davis and Rowland.

- Revising the federal share of the Medicaid costs to take into account the size and characteristics of each state's elderly population. By assuring that states with a greater need for services would receive more money to provide these services, this would help take some of the pressure off the need to contain costs.
- Establishing federal incentives and standards for Medicaid to insure minimum resource standards for eligibility (i.e., to protect an individual from impoverishment when his or her spouse enters a nursing home), scope of services covered, methods of paying providers, and utilization control mechanisms. This would help promote greater equity across states as well as increasing access and efficiency.[74]

[74]Feder and Scanlon, pp. 23-25.

Concluding Observations

Over the next several years, programs for the elderly could come under increasing review due to the projected growth in the share of public resources allocated to the elderly, Medicare's financing problems, and pressure to reduce the large federal deficit. If this occurs, several key issues and concerns regarding the current and projected economic and health status of the population 65 and older will need to be considered.

First, while the economic status of the elderly has improved over the last two decades, many elderly continue to have low incomes. Blacks, women, and individuals 85 and older are disproportionately represented among the elderly poor, and these groups are increasing at a faster rate than the rest of the elderly population. Further, much of the improvement in the economic status of the elderly is due to a great extent to the growth in Social Security and public and private retirement benefits. Any change in this support could potentially offset the economic gains of the past decades.

Second, many elderly already are experiencing problems due to the rising costs of health care. Twenty percent of the elderly population are particularly at risk because they lack supplemental insurance or Medicaid coverage and may be reducing utilization of health services because of their inability to pay for care. Their out-of-pocket costs also are likely to increase due to Medicare's financing problems under both HI and SMI. The HI trust fund is projected to be depleted in the late 1990's, and the increasing cost of SMI will make it a target for budget reductions in response to large deficits.

Finally, while rising costs for health care are a problem, the cost of long-term care services for some elderly is a financial catastrophe. The major public payer, Medicaid, provides financial help only when the individual becomes impoverished. Financing long-term care will become even more difficult and costly over the next several decades because the population most likely to need such care, the elderly age 85 and older, will be increasing at a faster rate than the total number of elderly.

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